Rhode Island Medicaid Program

Annual Report
Fiscal Year 2003

building health care programs to meet changing community needs

MESSAGE FROM THE DIRECTOR

Access to appropriate, effective health care remains a priority in Rhode Island. Rhode Island Medicaid cares for some of the state's most vulnerable populations and is an integral part of the state's overall health care system, serving 17 percent of Rhode Islanders.

The Department of Human Services produces the Medicaid Annual Report to provide the legislature, the administration and the public with information that will help these groups make informed decisions about Medicaid services and programming. The three sections of this year's report describe: (1) Medicaid's structure, financing and eligibility rules; (2) the programs, populations, expenditures and evaluation efforts overseen by DHS' Center for Adult Health; and (3) the programs, populations, expenditures and evaluation efforts overseen by the Center for Child and Family Health. The report covers all Rhode Island Medicaid expenditures, including those made through other state departments and local school districts.

In State Fiscal Year 2003, Medicaid spent $1.55 billion in state and federal funds to provide health care services to an average of 176,824 people each month. Medicaid provides access to health care for a range of populations including: elderly, persons with disabilities, children and families.

Given that the elderly and adults with disabilities are a growing segment of Rhode Island's population, 2003 saw a renewed emphasis on developing a statewide strategic vision for chronic and long-term care services. Adults with disabilities and the elderly account for 25 percent of the Medicaid population and 66 percent of total expenditures. The 24,543 adults with disabilities enrolled in Medicaid in fiscal year 2003 represent a six percent increase from 2002, while the elderly population increased four percent to 19,237. Overall, the expenditures for the adult population with disabilities under age 65 reached $500 million in 2003, an average of $1,693 per client per month. Over $391 million was spent on services for the aged, with an average monthly per client cost of $1,624.

Efforts to stabilize the growth of the successful RIte Care program continued in fiscal year 2003 as a greater number of RIte Care eligible children and families were enrolled in employer-sponsored health care coverage through RIte Share. By enrolling children and families in RIte Share, the state pays only the employee portion of the employer-sponsored premium instead of 100 percent of the premium under RIte Care. Total expenditures for 120, 895 children and families in RIte Care and RIte Share were $283 million in fiscal year 2003. The average monthly per client expenditure (including in-plan and out-of-plan services) for RIte Care was $194 and for RIte Share, the average monthly per client expenditure was $121. Overall, an average of 12,149 children with special health care needs were Medicaid eligible each month in fiscal year 2003. Total Medicaid spending on this population rose to $189 million, with an average monthly expenditure of $1,395 per child.

Rhode Island Medicaid continues to work hard to meet the challenges of improving the health and health care of the state's most vulnerable populations. The Department of Human Services and its partners are committed to increasing access and quality of care while containing costs, as we continue *Building Health Care Programs to Meet Changing Community Needs*. ▼

Jane A. Hayward

Jane A. Hayward
Director

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INTRODUCTION, ADMINISTRATION & OVERVIEW

INTRODUCTION

The Rhode Island Department of Human Services produces the Medicaid Annual Report as part of its role as the designated agency responsible for Medicaid. The Rhode Island Department of Human Services (DHS) is the Medicaid single state agency responsible to the federal government and the state for the effective, efficient administration and supervision of Rhode Island Medicaid and for assuring statewide accessibility to a comprehensive system of high-quality health care services for Medicaid recipients.

The Department began compiling an annual report on Medicaid in fiscal year 1999. The report was prepared in response to a request from state policymakers for additional information about Medicaid expenditures to assist in evaluating program outcomes and promote greater fiscal accountability.

Using information from fiscal year 2002 for comparison, the fiscal year 2003 annual report provides updates on changes in Medicaid populations and program expenditures. The report highlights the activities of the Center for Adult Health (which serves adults with disabilities and the elderly) and the Center for Child and Family Health (the Center serving children and families). The report outlines current program services and initiatives, summarizes health care expenditures and utilization rates and describes efforts at measuring access, quality and outcomes.

Rhode Island has seized every opportunity to use the greater flexibility the federal government has given the states over the past ten years, expanding access to and improving the quality of Medicaid health care services and coverage. The state has made particular efforts to extend coverage to new population groups in order to improve health care outcomes and decrease the rate of uninsurance in the state. While Rhode Island, like other states, has seen an increase in the number of uninsured residents, efforts to provide insurance coverage have helped to keep the uninsurance rate low, relative to other states. In 2002, Rhode Island's rate of uninsurance was 9.8 percent, the third lowest in the nation. In addition, Rhode Island has used its Waiver authority to provide specialized services to individuals who can benefit from them. These efforts have improved the lives of many adults with disabilities and elderly individuals who now have the option to obtain care in the community rather than in institutions. This flexibility has allowed Rhode Island Medicaid to implement its **Value-Based Purchasing Principle.**

When Medicaid began in the mid-1960s, the program was modeled on the indemnity health insurance plans that dominated the private market at that time. Under this "fee-for-service" model, Medicaid became a payer of medical claims incurred by its beneficiaries. A Medicaid recipient first identified a provider who would accept Medicaid's "fee-for-services performed" and then went to the provider for care. The provider submitted a bill to Medicaid, which Medicaid then paid. While some argue that a passive role is the natural order for a government-run program, others contend that this approach ignores the state's considerable potential to leverage the program's spending volume. This leverage enables Medicaid to conduct value-based purchasing in order to optimize the balance between the quantity, quality, and cost of services.

INTRODUCTION - CONTINUED

Throughout the 1990s, the Rhode Island Medicaid program, like others across the country, leveraged its purchasing power to transition from "payer" to "purchaser." Value-based purchasing involves contracting upfront with an organization that accepts payment for an agreed upon price for a specified service or range of services to Medicaid clients. The state, as the purchaser, sets standards (e.g., quality of care standards) for which the contracting organization is held accountable.

As a purchaser, the state can obtain services for all clients or subgroups of clients. The state can purchase one service, a specified range of services, or all Medicaid covered services. It can contract with one or many organizations/providers as needed. This process requires the state to develop and enforce contractual standards for health care quality and access. Value-based purchasing necessitates a good quality management system, including negotiated performance measures, member satisfaction surveys and focus groups, independent external reviews, data reporting and analysis, continuous quality improvement systems, and consequences for underachievers.

Over time, RI Medicaid has been shifting from being an after-the-fact payer of services to a value-based purchaser that can leverage its buying power to secure better and more cost-effective services and delivery systems for enrollees. This value-based purchasing principle enables Medicaid to promote better outcomes for the consumer and to gain more overall value for the public dollar.

Rhode Island Medicaid has also made changes to the range of populations it serves and the service delivery options it offers. Although Medicaid served a fairly limited population at its inception, state programs have been given incremental leeway to expand the individuals and families they cover. Rhode Island has chosen to provide Medicaid coverage to a number of optional groups. States can provide optional services, for which they receive federal matching funds.

The federal government requires the states to provide all Medicaid recipients with services that are comparable in scope, amount and duration. In the early 1980s, states were given the option to waive this and several other Medicaid requirements. Rhode Island established its first two Waivers in 1983, and now administers six Home and Community Based Services (HCBS) Waiver programs.

Rhode Island also administers a Section 1115(a) "research and demonstration" Waiver. Section 1115(a) Waivers allow states to explore new approaches to benefits, services, eligibility, program payments and service delivery. In 1994, Rhode Island used a Section 1115(a) Waiver to implement RIte Care, the state's Medicaid managed care program for eligible children and families. ▼

WHAT IS MEDICAID?

Medicaid is a federally sponsored health care program for individuals and families with limited incomes and resources. The program was established by the federal government in 1965 as Title XIX of the U.S. Social Security Act.

In the years since the program was created, Medicaid has become both the primary payer and purchaser of health care for many individuals and families in need. Today, Medicaid is the chief source of funding for: long-term care for individuals with limited-means; health care services for low-income adults with disabilities; and health care coverage for low-income families and their children and pregnant women and infants.

The federal government establishes core requirements concerning Medicaid funding, eligibility standards, and the quality and scope of medical services. Medicaid is an entitlement program; anyone who meets specified eligibility criteria may receive Medicaid services. Within this structure, states have flexibility to determine certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits and service delivery.

Title XIX requires that each state maintain a Medicaid State Plan that identifies the populations served, the criteria for determining eligibility, the scope of services provided, and the method of service delivery. The Medicaid State Plan is submitted for approval to the U.S. Centers for Medicare and Medicaid Services (CMS), the federal agency with oversight responsibility for state Medicaid programs. The Medicaid State Plan is an evolving rather than fixed document. A state must continually amend and/or revise its state plan to reflect the changes made in Medicaid program priorities and requirements.

Federal law also requires each state to centralize administrative, legal and financial responsibility for its Medicaid program in a "single state agency." The unit of government designated as such maintains the Medicaid State Plan, purchases the health care services and coverage authorized therein, and coordinates their delivery statewide. In Rhode Island, the single state agency is the Department of Human Services.

The Balanced Budget Act of 1997 added a new section to the Social Security Act - Title XXI. Title XXI established the State Children's Health Insurance Program (SCHIP), a federal/state program designed to provide health insurance coverage to previously uninsured children. Each state designed its own program within established federal guidelines. Rhode Island built on its previous expansion of child and family coverage by using SCHIP funding to expand its existing Medicaid program to cover more children.

For a detailed history of the Medicaid program see the DHS website *www.dhs.ri.gov* ▼

ADMINISTRATION OF RHODE ISLAND MEDICAID

The Department of Human Services is the designated single state agency with responsibility and accountability for the Medicaid program in Rhode Island. As the single state agency, DHS has statutory responsibility for:

1. **Oversight of the Medicaid State Plan.** The DHS must administer or supervise the implementation of all aspects of the Medicaid State Plan, including ensuring the correctness and accuracy of all financial and program reports as well as overseeing the scope and accessibility of services. The DHS cannot delegate its duties and responsibilities to other state or local agencies, although DHS is specifically authorized to enter into cooperative arrangements with other state and local agencies to maximize the utilization and coordination of medical assistance within Rhode Island.
2. **Statewide service availability, adequacy, quality.** The DHS is required to ensure that Medicaid services are available statewide.
3. **Statewide access to efficient eligibility determination.** The DHS is required to provide all Rhode Island residents with the opportunity to apply for medical assistance, assure that eligibility will be appropriately determined, and make sure that the state will furnish medical assistance with reasonable promptness, in a manner consistent with simplicity of administration and the best interests of the recipients.
4. **Choice of and equitable access to service providers.** The DHS is required to assure that individual recipients have a choice of providers both within the fee-for-service and managed care components of the program, while at the same time assuring that methods and payment rates are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available to the Medicaid population in all geographic areas of the state.
5. **Sufficient availability of basic services, including the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.** The DHS is required to assure that services are of sufficient amount, duration and scope for both mandatory and optional services; and that EPSDT screenings and necessary medical services are available to Medicaid eligible persons under age 21.

Each state must determine how to administer the program across multiple agencies that have overlapping responsibilities and authorities to serve a variety of eligible populations. As indicated in (1) above, DHS may enter into cooperative agreements with other state agencies in order to maximize the utilization and coordination of services for the Medicaid population; however, DHS cannot delegate its duties or responsibilities.

Within these parameters and under Rhode Island state statutes, the Department of Human Services has shared stewardship for Rhode Island Medicaid with other agencies:

- Department of Mental Health, Retardation and Hospitals (MHRH)
- Department of Children, Youth and Families (DCYF)
- Department of Health (DOH)
- Department of Elderly Affairs (DEA)
- Local Education Agencies (LEAs)

The relationships that constitute this shared stewardship are complex. **Exhibit 1** illustrates the services that are either purchased or provided by each state agency on behalf of the four Medicaid population subgroups.

EXHIBIT 1

Rhode Island Medicaid Purchased and Directly Provided Services by Department FY 2003

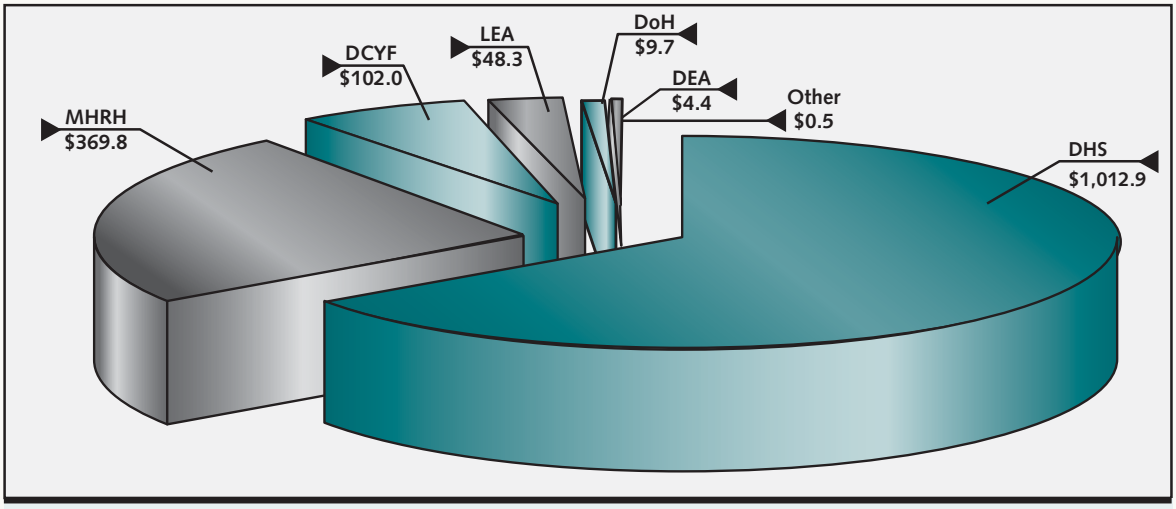
Population	Department of Human Services	Department of Children, Youth and Families	Department of Mental Health, Retardation and Hospitals	Department of Elderly Affairs	Department of Health	Local Education Agencies
Adults with Disabilities	Basic Medicaid services through direct pay to fee-for-service providers; Home and community based services		Behavioral health services to adults with severe and persistent mental illness; Substance abuse treatment; Certain home and community based services including group homes for adults with developmental disabilities and mental retardation; Slater Hospital	Certain home and community based services	Targeted case management for people with AIDS State laboratory	
Elderly Adults	Basic Medicaid services through direct pay to fee-for-service providers; Home and community based services		Behavioral health services to adults with severe and persistent mental illness; Substance abuse treatment; Certain home and community based services including group homes for adults with developmental disabilities and mental retardation; Slater Hospital	Certain home and community based services	State laboratory	
Children and Families in Managed Care	Basic Medicaid services through Health Plans plus fee-for-service wrap-around services; CEDARR Family Services	Certain behavioral health services	Substance abuse treatment		State laboratory	Case management and school-related services; Individualized education plans (IEPs) for Medicaid-eligible special education students
Children with Special Health Care Needs	Basic Medicaid services through direct pay to fee-for-service providers; Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) family services	Residential placement; Certain behavioral health services	Substance abuse treatment		State laboratory	Case management and school-related services; Individualized education plans (IEPs) for Medicaid-eligible special education students

ADMINISTRATION - CONTINUED

Exhibit 2 illustrates the total FY 2003 state and federal expenditures for the Medicaid program by department. For a listing of programmatic partnerships and participating Departments and other stakeholders, please see the DHS web site at *www.dhs.ri.gov.*

Exhibit 3 displays the eligibility pathways and the service delivery system options available to each subgroup. The population has been divided into these four categories based on similarities of service need and complexity, as related to age, family structure and disability.

EXHIBIT 2
RI Medicaid Total Expenditures by Department in Millions - FY 2003



DHS - Department of Human Services
MHRH - Department of Mental Health, Retardation and Hospitals
DCYF - Department of Children, Youth and Families
LEA - Local Education Agencies
DoH - Department of Health
DEA - Department of Elderly Affairs

EXHIBIT 3
Rhode Island Medicaid Eligibility Pathways and Delivery System Options (as of June 30, 2003)

Medicaid Population Subgroup	Eligibility Pathways	Delivery System Options
Children and families in managed care **(Children under 19 and their parents)**	• FIP/TANF • Section 1115 Waiver eligible • SCHIP • Certain poverty level children who are not eligible for TANF • 1931(e) Expansion parents	• Enrollment in a RIte Care Health Plan or Rite Share Premium Assistance Program plus limited FFS to fill in gaps in coverage • CEDARR
Children with special health care needs (as an eligibility factor) **(Under age 22)**	• Children who are – Blind and disabled SSI recipients – Katie Beckett eligible (eligible up to 18th birthday) – Substitute care – Subsidized adoption	• Traditional Fee-for-Service (FFS) • Enrollment in a RIte Care Health Plan plus limited FFS to fill in gaps in coverage • CEDARR
Adults with disabilities* **(Age 22-64)**	• Blind and disabled SSI recipients • Medically needy • Medicare recipients below certain income level • Long term care eligible	• Traditional FFS • Connect CARRE • Waiver programs – Mentally Retarded and Developmentally Disabled (MHRH) – Aged and Disabled – Physically Disabled (PARI) – Assisted Living (DEA)
Aged* **(Age 65 and over)**	• Aged, blind and disabled SSI recipients • Medically needy • Medicare recipients below the poverty level	• Traditional FFS • Assisted Living Waiver (DEA) • Elderly Waiver (DEA) • Aged and Disabled Waiver • Physically Disabled (PARI) • Mentally Retarded and • Developmentally Disabled Waiver (MHRH)

*** effective July 1, 2001, as authorized by the state budget, DHS increased eligibility for services to aged and disabled individuals with incomes up to 100 percent of the federal poverty level.**

ADMINISTRATION - CONTINUED

Within DHS, the Division of Health Care Quality, Financing and Purchasing (the "Division") is responsible for administering the Rhode Island Medicaid program. The Division's program development, administration and staff are located in three centers:

- Center for Adult Health
- Center for Child and Family Health
- Center for Finance and Administration

The Division has been implementing its consumer-focused value-based purchasing philosophy by adopting the following operating principles to develop and manage its programs:

- Assess consumer needs.
- Involve consumers in decisions that affect the services they receive.
- Involve providers in defining performance expectations that respond to consumer needs and assure the quality and accountability of service provision.
- Define benefits, design payment methodologies and create contract structures that support:
  - The improved health status of the consumer population;
  - The ability to obtain and maintain work opportunities for those with disabilities;
  - The cost-conscious expenditure of public funds; and
  - The use of data to track progress, inform decisions and continuously improve programs.

The Center for Adult Health (CAH) and the Center for Child and Family Health (CCFH) are responsible for program and policy development for the four Medicaid population subgroups. The activities of these two Centers are discussed in detail within the sections that follow.

In addition to administering programs for adults with disabilities and elderly adults, CAH oversees the Medicaid Management Information System (MMIS) on behalf of the Division. The MMIS processes medical claims, makes capitation payments, enrolls providers, maintains eligibility information and utilization reports. The Division is responsible for developing policies and procedures as well as monitoring the activities of its fiscal agent, Electronic Data Systems Corporation (EDS), as related to claims processing, provider relations and report generation.

As coordinator of the MMIS function, CAH has major responsibility for the implementation of and compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The intent of this federal legislation is to improve the availability and portability of health coverage through a variety of provisions. In addition, HIPAA, through its Administrative Simplification provision, requires the adoption of national standards for the electronic transfer of health care information including codes, identifiers, security and privacy. HIPAA requires that covered-entities, which include healthcare providers, insurers and healthcare claim billing clearinghouses, comply with published Federal rules or become subject to civil and criminal fines and sanctions. The RI Department of Human Services is the single-state agency responsible for ensuring that Medicaid operations, including those programs co-administered by several sister State agencies, become compliant with HIPAA regulations. Medicaid operations are widely dispersed within RI State government; therefore, a cohesive and coordinated effort has been necessary to ensure that all Federal mandates are implemented.

ADMINISTRATION - CONTINUED

Compliance with the HIPAA Privacy Rule was due on April 14, 2003, and much effort was expended during the year to accomplish this goal. DHS mailed its Notice of Privacy Practice to all Medicaid beneficiaries before the compliance date and held many HIPAA Privacy training seminars for staff throughout the spring and summer of 2003. DHS also completed and disseminated a HIPAA-compliant medical release authorization form and established a HIPAA privacy call center.

MMIS system remediation in Rhode Island is being carried out by the Medicaid Fiscal Agent as part of a multi-state effort whose goal is to leverage available resources and minimize HIPAA compliance costs. MMIS system remediation was substantial during 2003 with efforts aimed primarily at converting current proprietary healthcare claim transactions to the national X12N standards. Compliance with the NCPDP 5.1 pharmacy standard was accomplished on July 1, 2003 - all RI pharmacies now transact business with Medicaid using the HIPAA compliant version. Successful conversion to national standards regarding healthcare transactions and code sets took place in the fall 2003.

In addition to administering programs for children and families in managed care, children with special needs and children in foster care, CCFH oversees research and evaluation on behalf of the Division. The approach to research and evaluation originates from Medicaid's overarching goal, "to improve the health of the Medicaid population and, by so doing, improve the health of Rhode Island's population overall." Rhode Island Medicaid is working to ensure that programs measurably improve the health of the Medicaid population, and so need to be able to measure progress toward that goal. Research efforts assist programs by measuring and assessing progress. Information related to research and evaluation initiatives can be found on the DHS web site at *www.dhs.ri.gov.*

The Center for Finance and Administration (CFA) encompasses all the core administrative functions of the Medicaid program: budgeting; financial expenditure analysis; financial control of the MMIS; financial reporting; hospital-related service monitoring and payment; program integrity; recoveries from third parties for claims liability; estate recoveries; and calculation and distribution of the disproportionate share program (DSH) for uncompensated care in Rhode Island hospitals.

The CFA administers the Prospective Hospital Reimbursement Program as the Department of Administration's designee. This program has its origins in state law. In 1971, amendments were added to the enabling legislation for nonprofit hospital service corporations, i.e., Blue Cross of Rhode Island. These amendments mandated that hospital budget negotiations were necessary for the purpose of determining payment rates for hospitals.

The current participants in the program are the State of Rhode Island, the thirteen voluntary hospitals in the state and Blue Cross of Rhode Island. The major components of the program are: a negotiated statewide maximum ceiling on reimbursable expenses (MAXICAP); negotiated individual hospital operating budgets; and establishment of third-party payment rates for inpatient and outpatient services. ▼

WHO IS ELIGIBLE?

All state Medicaid programs must cover the following people:

1. Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI)[1];
2. Low income Medicare beneficiaries.
3. Individuals who would qualify for Aid to Families with Dependent Children Program (AFDC) today under the state's 1996 AFDC eligibility requirements[2];
4. Children under age six and pregnant women with family income at or below 133 percent of federal poverty guidelines;
5. Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level;
6. Infants born to Medicaid-enrolled pregnant women;
7. Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program;

In addition, Rhode Island Medicaid has chosen to cover these optional groups:

1. Low-income elderly adults or adults with disabilities;
2. Individuals eligible for Home and Community Based Services Waiver programs.
3. Children and pregnant women up to 250 percent and parents up to 185 percent of the federal poverty level, including children funded through the State Children's Health Insurance Program (SCHIP);
4. Individuals determined to be "medically needy" due to low income and resources or to large medical expenses;
5. Children under 18 with a disabling condition severe enough to require institutional care, but who live at home (the "Katie Beckett" provision);
6. Women eligible for the breast and cervical cancer program.

1. SSI is a federal income assistance program for disabled, blind or aged individuals that is independent of individuals' employment status. SSDI is an insurance program for those who have worked a specified amount of time and have lost their source of income due to a physical or mental impairment.
2. Federal policymakers severed the tie between medical and cash assistance when the AFDC program was replaced in 1996. The AFDC standard was retained in Title XIX to prevent the states from using the more restrictive eligibility requirements and time limits of AFDC's successor – Temporary Assistance for Needy Families or TANF – when providing Medicaid coverage to needy children and families.

WHO IS ELIGIBLE? - CONTINUED

Within DHS, the Division of Health Care Quality, Financing and Purchasing administers the Rhode Island Medicaid program. The program manages services for four population subgroups across two Centers:

The Center for Adult Health manages:

- Adults with disabilities; and
- Elderly adults

The Center for Child and Family Health manages:

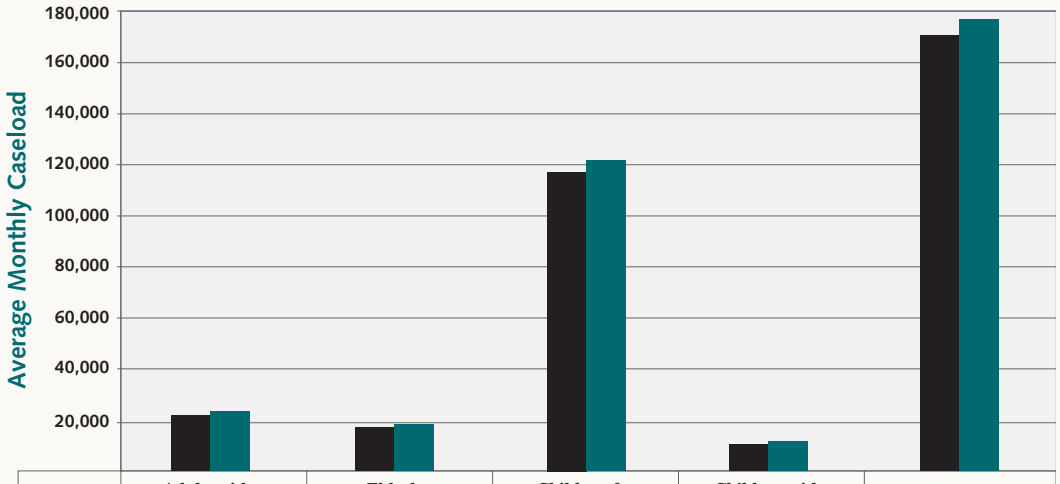
- Children and families in managed care
  - RIte Care
  - RIte Share
- Children with special health care needs, including:
  - Children eligible due to SSI
  - Children eligible due to the Katie Beckett provision
  - Children in Subsidized Adoption
  - Children in Foster Care

Exhibit 4 displays the average monthly caseload[3] of Medicaid recipients by subgroup for fiscal year 2003. The total of 176,824 recipients are distributed as follows:

- 24,543 adults with disabilities
- 19,237 elderly adults
- 120,895 children and families in managed care (includes 3,018 RIte Share enrollees)
- 12,149 children with special health care needs

EXHIBIT 4

Rhode Island Medicaid Average Monthly Caseload by Population Subgroup - FY 2002 and FY 2003



Subgroup	Adults with Disabilities	Elderly	Children & Families in Managed Care*	Children with Special Health Care Needs**	TOTAL
FY 2002	23,116	18,568	117,460	11,296	170,440
FY 2003	24,543	19,237	120,895	12,149	176,824

*includes RIte Share **includes children in foster care

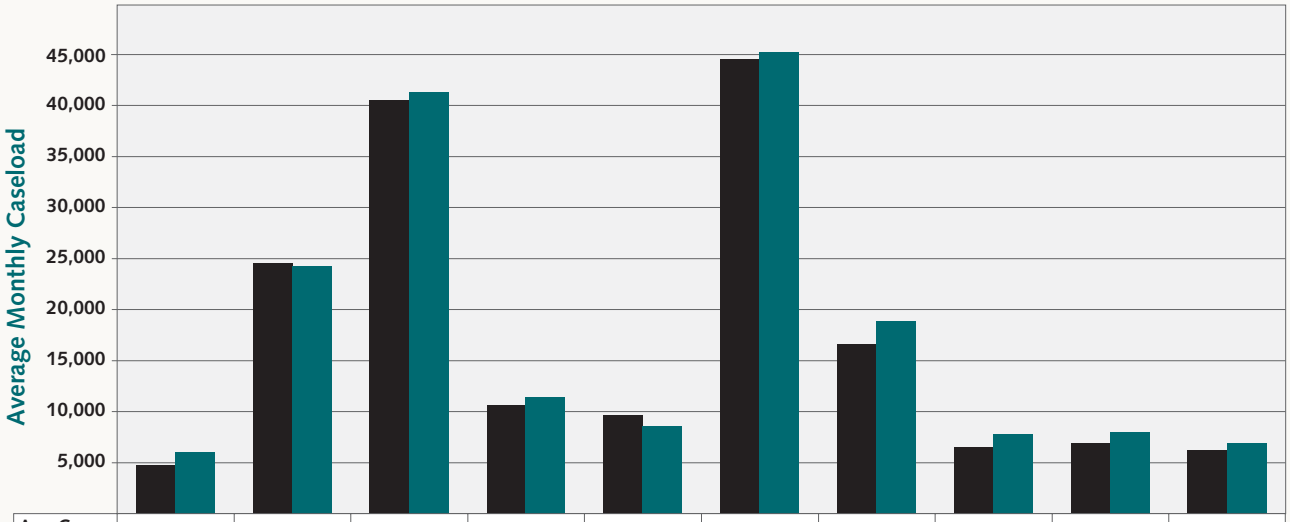
3. The average monthly caseload of Medicaid recipients represents the number of individuals enrolled in a given month regardless of the length of time they were eligible (from 1 to 31 days). The average monthly caseload for the year is calculated by averaging the monthly caseload for 12 months. The unduplicated count of Medicaid recipients represents the number of unique individuals enrolled during the year regardless of the length of time they were eligible (from 1 to 365 days). The unduplicated count is higher than average monthly caseload. Average monthly caseload is used in most budgeting and financial calculations and in the caseload estimating conferences

WHO IS ELIGIBLE? - CONTINUED

Exhibit 5 displays the FY 2003 Medicaid population by age group.

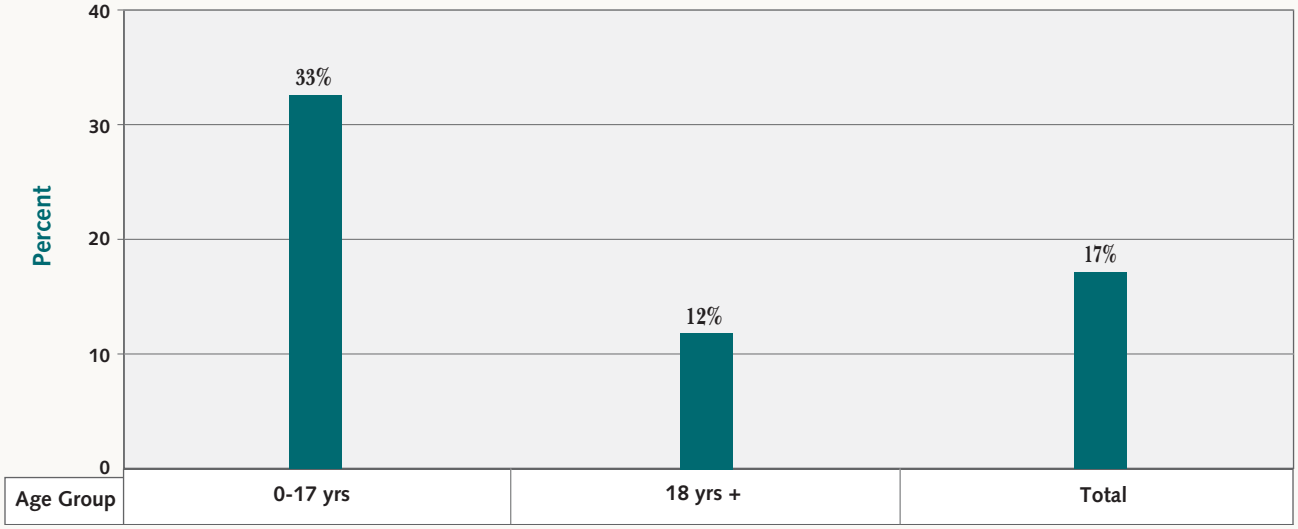
Exhibit 6 displays the Medicaid population as a percent of the Rhode Island populations of children and of adults. Overall, Medicaid recipients made up 17 percent of the state population. Medicaid covered an estimated 33 percent of all Rhode Island children under age 18 years and 12 percent of persons 18 years and older during 2003. ▼

EXHIBIT 5
Rhode Island Medicaid Average Monthly Caseload by Age Group - FY 2002 and FY 2003



Age Group	0-1 yrs	1-5 yrs	6-14 yrs	15-17 yrs	18-21 yrs	22-44 yrs	45-64 yrs	65-74 yrs	75-84 yrs	85 yrs +
FY 2002	4,973	24,610	40,474	10,542	9,686	44,489	16,427	6,473	6,723	6,045
FY 2003	5,825	24,442	41,043	11,250	8,221	45,091	18,816	7,545	7,757	6,833

EXHIBIT 6
Rhode Island Medicaid Average Monthly Caseload as a Percent of Rhode Island Population FY 2003



WHAT SERVICES ARE COVERED?

Exhibit 7 lists the services covered by Rhode Island Medicaid. All recipients are eligible to receive "Basic Medicaid Services" unless otherwise specified. Please note that:

- To be eligible as medically needy, a recipient must have income and resources below specified limits, or have large medical expenses;
- To be eligible for Waiver services, recipients must meet specific criteria. (For information on Waiver programs, please see the DHS web site at *www.dhs.ri.gov*)
- To be eligible to participate in federal Medicare buy-in, a recipient must meet Medicare requirements and have income and resources below specified limits.

EXHIBIT 7
Rhode Island Medicaid State Plan Services
FY 2003

Basic Medicaid Services — Mandatory State Plan Services plus Optional State Plan Services offered in RI, i.e.:

Mandatory State Plan Services

States are required to offer coverage to the categorically needy for these services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and x-ray services
- Nursing facility services for individuals 21 and older
- Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21
- Family Planning services
- Physicians' services
- Home health services for any individual entitled to nursing facility care
- Nurse-midwife services to the extent permitted by State law
- Services of certified nurse practitioners and certified family nurse practitioners to the extent they are authorized to practice under State law

Optional State Plan Services offered in RI

- Podiatrists' services
- Optometrists services
- Dental services
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Diagnostic services
- Preventive services
- Rehabilitative services
- Services in an IMD for individuals age 65 and over
- Inpatient psychiatric services for individuals under age 21
- NF services for individuals under age 21
- Personal care services
- Transportation services
- Case management services
- Hospice services
- TB services for certain TB infected individuals

Medically Needy State Plan Services — prenatal & delivery for pregnant women, ambulatory services for individuals under 18 and those entitled to institutional care, home health services for individuals entitled to nursing facility services, mandatory state plan services for over 65 & under 21 in an IMD or ICF/MR.

Waiver Services — Home or community based services not otherwise furnished under the State's Medicaid plan and have been approved under a waiver request to HCFA. These consist of any or all of the following: case management services, homemaker services, personal care services, adult day health services, habilitation services, respite services, minor assistive devices, minor modifications to the home, and other medical or social services as requested by the state and found to be cost-effective to prevent institutionalization.

Federal Medicare Buy-in — direct payment or annual stipend to pay Medicare deductibles, co- payments and coinsurance, only.

Employer Sponsored Health Insurance (ESI) Premium Assistance — If cost-effective, the state pays the employees share of ESI premium if Medicaid eligible has access to ESI.

Enrollee Co-premium — Under managed care programs for children and familes, enrollees must pay a sliding scale co-premium based on family income.

HOW IS MEDICAID FINANCED?

The federal and state governments each contribute funds to Medicaid. For administrative costs, the federal government contributes 50 percent of total expenditures, with enhanced federal funding provided for some administrative activities, such as fiscal agent operations. For medical services, the federal government contributes at least 50 percent of total expenditures. The federal matching assistance percentage (FMAP) varies across states and is adjusted annually. States with lower per capita incomes receive a higher federal match. The FMAP ranges from the minimum of 50 percent in California, Colorado, Connecticut, Delaware, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York and Washington, to almost 77 percent in Mississippi. The Medicaid FMAP for Rhode Island was 56.40 percent in federal fiscal year 2003. To alleviate the budget crisis facing states, federal legislation was passed in May 2003 to provide temporary fiscal relief through an increase in the FMAP rate. Rhode Island will receive an additional $10 million in federal funds between April 2003 and June 2004.

Exhibit 8 displays Rhode Island's FMAP rate from 1999 through 2005 for Title XIX (Medicaid) and Title XXI (State Children's Health Insurance Program (SCHIP)[4] expenditures. Medicaid enrollment is not limited based on a pre-set expenditure cap. By federal law, eligible individuals cannot be denied enrollment or covered services based on insufficient government funds.

EXHIBIT 8
RI Medicaid State & Federal Matching Rates 2001 to 2005

MEDICAID TITLE XIX		
Federal FY	**State %**	**Federal %**
2001	46.21%	53.79%
2002	47.55%	52.45%
2003*	43.60%	56.40%
2004*	43.97%	56.03%
2005	44.62%	55.38%
SCHIP TITLE XXI		
Federal FY	**State %**	**Federal %**
2001	32.35%	67.65%
2002	33.28%	66.72%
2003	31.22%	68.78%
2004	30.78%	69.22%
2005	31.23%	68.77%

Source: Center for Medicare and Medicaid Services
under P.L. 108-27, the Jobs and Growth Reconciliation Act, the federal match was increased by 2.95 points so that from April 2003 to September 2003 the FMAP was 58.35% and from October 2003 to June 2004 the FMAP will be 59.98%.

EXHIBIT 9
Rhode Island Medicaid Total Expenditures FY 2003

Line Items/ Departments	Expenditures	Percent
Hospital - Regular	$ 109,004,628	7.0%
Hospital - Disproportionate Share payments	$ 93,166,810	6.0%
Nursing Homes	$ 260,799,967	16.9%
Managed Care	$ 282,448,866	18.3%
Other	$ 220,058,782	14.2%
Restricted Receipt	$ 4,422	0.0%
Administration-DHS	$ 47,446,665	3.1%
Total DHS	$1,012,930,140	65.5%
Total MHRH	$ 369,783,353	23.9%
Total DCYF	$ 101,992,444	6.6%
Total LEA*	$ 48,266,073	3.1%
Total DOH	$ 9,655,543	0.6%
Total DEA	$ 4,441,738	0.3%
Total Other	$ 501,827	0.0%
TOTAL ALL DEPARTMENTS	**$1,547,571,118**	**100.0%**

DHS: RI Department of Human Services
MHRH: RI Department of Mental Health, Retardation and Hospitals
DCYF: RI Department of Children, Youth and Families
LEA: Local Education Authorities
DOH: RI Department of Health
DEA: RI Department of Elderly Affairs

* increase in LEA is a result of the newly authorized recapture of administrative costs for local education expenses

4. Through SCHIP, the federal government provides states with an "enhanced" FMAP rate to encourage enrollment of children in the program.

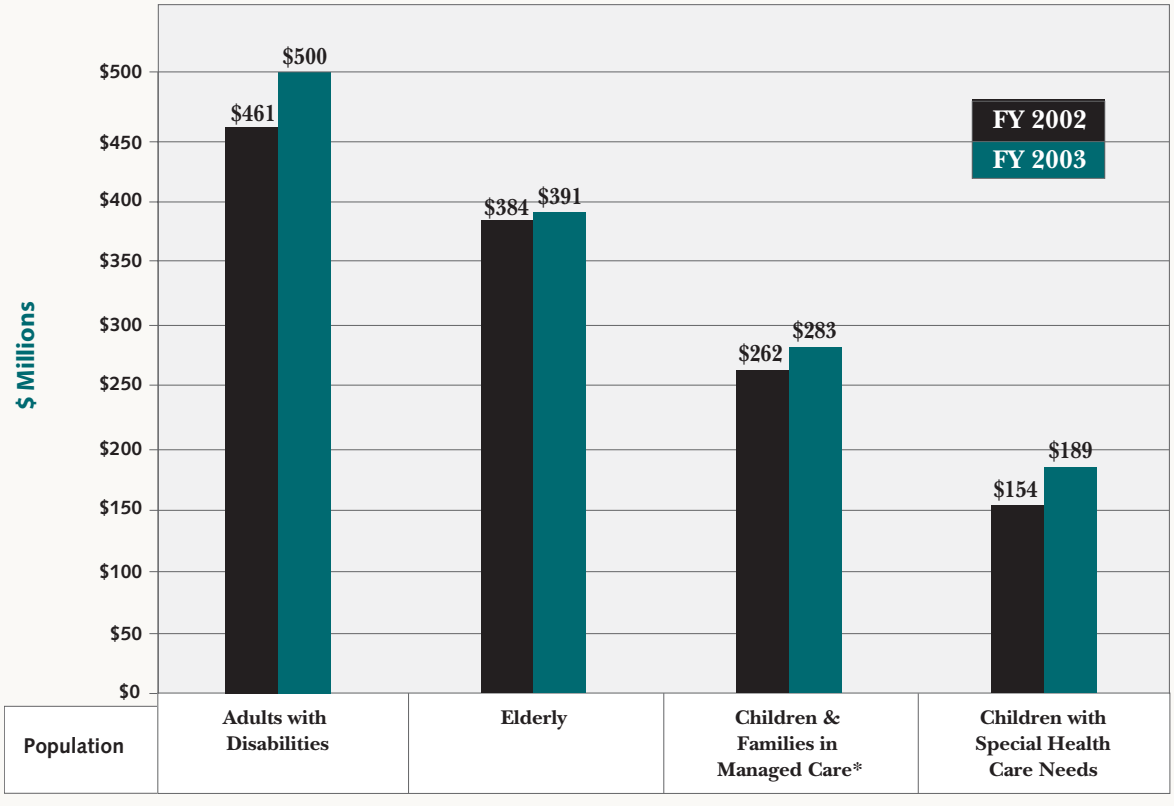
HOW IS MEDICAID FINANCED? - CONTINUED

Exhibit 9 shows total combined federal and state expenditures for Rhode Island Medicaid in FY 2003. Total expenditures for benefits and administration were $1.55 billion. Medicaid expenditures constitute a sizable proportion of the total state budget. In fiscal year 2003, Medicaid accounted for 25.8 percent of the state budget. ▼

HOW ARE MEDICAID DOLLARS USED?

Exhibit 10 displays Medicaid expenditures by population group. Total program expenditures grew 7 percent between fiscal years 2002 and 2003. The largest absolute increase, i.e., $39 million occurred in the adults with disabilities subgroup. The largest percentage increase, i.e., 23 percent, occurred in the children with special health care needs subgroup.

EXHIBIT 10
Rhode Island Medicaid Program Expenditures by Population Subgroup - FY 2002 and FY 2003 ($ in Millions)



* includes RIte Share

HOW ARE MEDICAID DOLLARS USED? - CONTINUED

Exhibit 11 compares the caseload distribution for each subgroup with the associated distribution of expenditures. While children and families in managed care represent 68 percent of the total caseload, they account for only 21 percent of program expenditures. Conversely, adults with disabilities and the aged combined represent 25 percent of the total caseload but account for 66 percent of all expenditures. In addition, children with special health care needs represent 7 percent of total caseload and account for 14 percent of all expenditures.

Exhibit 12 displays medical expenditures by category of service provider, ranked by expenditure volume:

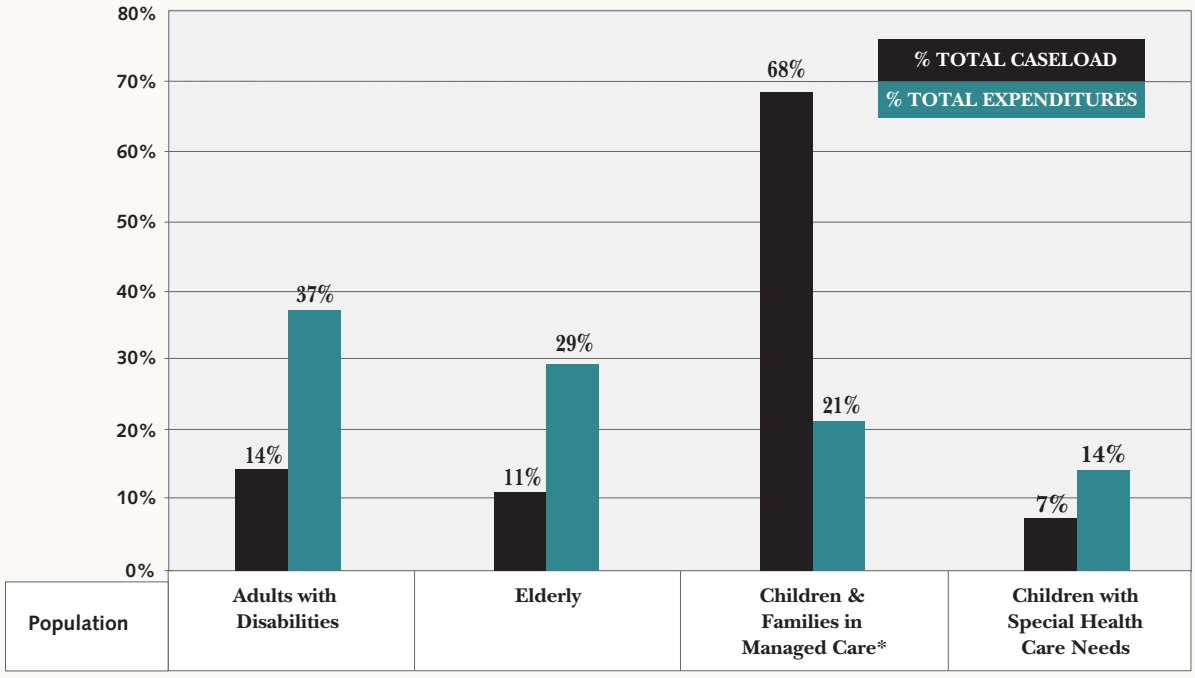
- $369 million for home and community based services
- $368 million for institutional service providers (nursing homes and Eleanor Slater Hospital)
- $178 million for pharmaceuticals
- $175 million for acute-care hospitals
- $145 million for physicians and other services
- $128 million for providers of behavioral health services

PER CAPITA PER MONTH EXPENDITURES

Average per capita per month (PCPM) costs are shown in **Exhibit 13.** The per capita spending on children and families in managed care is significantly lower than the PCPM for other populations. In 2003, the PCPM for children with special health care needs increased the most, i.e., 22 percent, over the previous year. The PCPM for the elderly decreased two percent from FY 2002. ▼

EXHIBIT 11

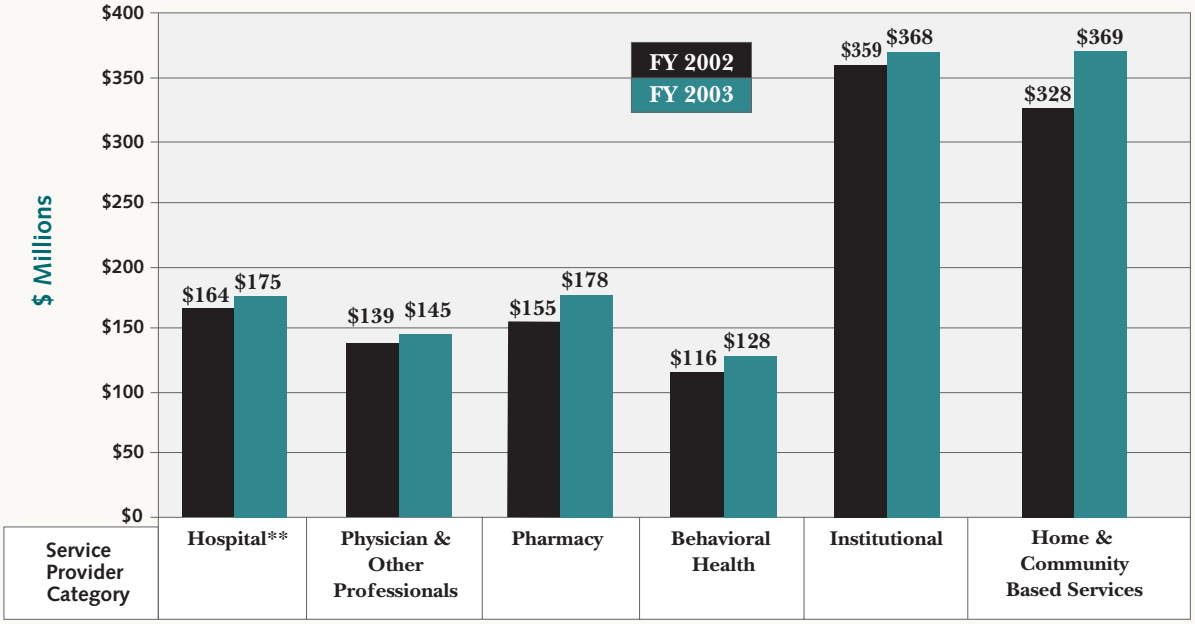
Rhode Island Medicaid Percent Program Expenditures vs Percent Caseload by Population Subgroup - FY 2003



* includes RIte Share

EXHIBIT 12

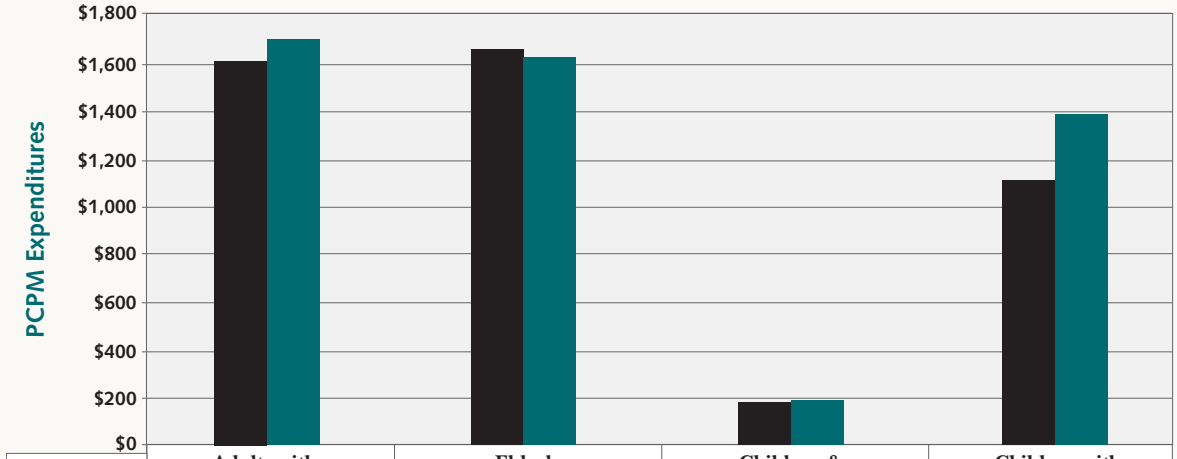
Rhode Island Medicaid Program Expenditures* by Service Provider Category FY 2002 and FY 2003 ($ in Millions)



*excludes RIte Share **excludes disproportionate share payments

EXHIBIT 13

Rhode Island Medicaid Per Capita Per Month (PCPM) Program Expenditures – FY 2002 and FY 2003



Population	Adults with Disabilities	Elderly	Children & Families in Managed Care	Children with Special Health Care Needs
FY 2002	$1,611	$1,659	$184	$1,139
FY 2003	$1,693	$1,624	$194	$1,395

*excludes RIte Share

CENTER FOR ADULT HEALTH

PROGRAMS & INITIATIVES

WAIVER PROGRAMS

Most of the adults with disabilities and elderly adults enrolled in Medicaid receive services through the traditional Medicaid program. In addition, some individuals participate in one of Rhode Island's six home and community based services (HCBS) Waiver programs. Waiver program participants receive home and community based services along with the full range of traditional Medicaid services.

The Department of Human Services (DHS) administers the **Aged and Disabled** Waiver program. Enrolled individuals are eligible for case management, personal care, environmental modifications, special medical equipment, Meals-on-Wheels, senior companion and emergency response services. The Waiver was initially approved in 1983 and is approved through 2003. In fiscal year 2003, 1,617 individuals received services through the Aged and Disabled Waiver program.

The **Physically Disabled** Waiver is administered through a partnership between the Department of Human Services (DHS) and the People Actively Reaching Independence (PARI) Independent Living Center. Independent living agencies provide case management and personal care services for individuals with quadriparesis or functional hemiparesis. Participants may receive case management, a personal care attendant, consumer preparation, environmental modifications, special medical equipment, homemaker services and emergency response services. Eighty-two (82) individuals received services through this Waiver in FY 2003. The Waiver began in 1988 and is approved through 2004.

The **Assisted Living** Waiver is a collaborative effort of DHS and Department of Elderly Affairs, and it provides services to some individuals residing in assisted living facilities. The Waiver funds case management, assisted living and special medical equipment for eligible individuals residing in assisted living facilities. The Waiver began in 1999 and in 2002 was re-approved through 2007. Two hundred forty-eight (248) people received services through this Waiver in FY 2003.

The DHS and the Department of Mental Health, Retardation and Hospitals (MHRH) administer the **Mentally Retarded/Developmentally Disabled** Waiver. Services funded under this Waiver include case management, specialized homemaker, adult foster care, homemaker, respite, environmental modifications, special medical equipment, residential day habilitation and supported employment. In FY 2003, two thousand two hundred nineteen (2,219) persons received Waiver services. The Waiver program was initiated in 1983 and is approved through 2006.

The DHS and Department of Elderly Affairs (DEA) administer a Waiver for **Community Based Elderly** Medicaid recipients. Eligible individuals must be over age 65, and can receive case management, homemaker, personal care, Meals-on-Wheels, senior companion, environmental modifications and special medical equipment. In FY 2003, five hundred twenty-three (523) Rhode Islanders received services under this Waiver. The Waiver began in 1988 and is approved through 2006.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

The **Habilitation** Waiver is administered through a partnership between the Department of Human Services (DHS) and the People Actively Reaching Independence (PARI) Independent Living Center. The independent living agency provides case management and works with MHRH certified providers and licensed home health agencies to arrange for needed residential and day habilitation services, private duty nursing, supported employment, special medical equipment, minor home modifications, personal emergency response units and community-based rehabilitation services. The Waiver began in 2001 and is approved through 2004. Four people received these Waiver services in FY 2003.

LONG TERM CARE INITIATIVE

State policy makers have long expressed concern about the escalating cost of and increasing demand for high-quality long-term care services for elderly individuals and those with chronic disabilities. Recently, financial pressures, workforce shortages and the state's aging population, among other issues, have heightened concern about the capacity and fiscal viability of the state's long term care system. In response to these and other concerns, the Governor and General Assembly established the Joint Long Term Care Administration/Legislative Work Group to search for workable solutions. The Committee was charged with identifying the state's options for strengthening the system and making sustainable reforms and establishing a strategy for implementing such efforts. The Committee outlined the essential elements of and steps in the reform process, and developed a path for shaping legislatively sustainable reform.

In fiscal year 2002, the state legislature passed a joint resolution to reform and finance long-term care services through a consumer-centered system of coordinated services and integrated care. It directs the state agencies to both shore up the long-term care system and develop infrastructure to support improvements.

On October 3, 2003, Governor Donald L. Carcieri signed Executive Order 03-15 establishing the Governor's Cabinet on Chronic and Long Term Care to better coordinate state-administered programs supporting the needs of Rhode Island's seniors and adults with chronic conditions or disabilities. Modeled on the RI Children's Cabinet, the Chronic and Long Term Care Cabinet brings together key department directors to continue the discussions held as part of the Living Rite initiative and further consider a wide range of issues, including the implications of increased demand for services, the availability of providers, the quality of services furnished, and the effectiveness and efficiency of current delivery systems.

One of the Cabinet's first undertakings will be the design and implementation of a One-Stop Aging and Disability Resource Center. The state received a three-year federal grant from the Administration on Aging and the Centers for Medicare and Medicaid Systems to support this multi-agency initiative. The Resource Center will provide both physical and virtual access to all long term care supports through closely coordinated intake, assessment, eligibility screening and determination, and resource referral to both public and private consumers in Rhode Island.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

BREAST AND CERVICAL CANCER PROGRAM

Taking advantage of a federal coverage option, the Department of Human Services and Department of Health in concert with representatives of women's cancer organizations designed and implemented a program to allow women with breast or cervical cancer or pre-cancerous symptoms to gain Medicaid eligibility. To be eligible a woman must be screened by the DOH-administered Women's Cancer Screening Program. The screening program is funded by the Federal Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program. The screening program provides no-cost pelvic exams, Pap tests, clinical breast exams, and mammograms to uninsured, low-income women.

Any woman screened by a provider who participates in the program and found to have cancer or pre-cancerous symptoms can enroll in Medicaid for the duration of her treatment. Although eligibility for coverage is based on the woman's need for cancer-related treatment, enrolled women are eligible to receive the full scope of Medicaid services.

Coverage was provided to 159 new participants during fiscal year 2003. Of the total, thirty-nine (39) had either breast or cervical cancer and one hundred twenty (120) were eligible due to a pre-cancerous condition. A woman is eligible for coverage under this program until one of the following occurs: her course of treatment for breast or cervical cancer ends; she turns 65; she gains creditable coverage; she fails to complete a scheduled redetermination; or she is no longer a Rhode Island resident. Since its inception in April 2001, three hundred fifty (350) women have benefited from this program. Currently there are 183 women actively enrolled.

TBI IMPLEMENTATION GRANT

In March 2002, the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) awarded a three-year, $600,000 Traumatic Brain Injury (TBI) Implementation Grant to the DHS Center for Adult Health. The successful completion of the Rhode Island Plan for TBI Services under the DHS 2000 HRSA TBI Planning Grant led to this proposal and subsequent award.

Highlights of the project for FY 2003 include:

- The opening of a comprehensive Brain Injury Resource Center on Park Avenue in Cranston in December 2002 for TBI survivors, family members and professionals that responded to over 400 requests for information.
- Training videotapes and curricula about specific needs of Brain Injury survivors for providers of Service Coordination, Vocational Services, Developmental Disability Services, Home Health Care, Behavioral Health and Substance Abuse Services are being developed.
- Over 18,000 multi-language fact sheets and concussion cards were distributed statewide.
- Annual conference for survivors, families and professionals in March 2003 had over 200 participants, and
- Multiple educational presentations and media broadcasts were conducted statewide.

The Brain Injury Association of Rhode Island is under contract with the DHS Center for Adult Health to conduct grant activities.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

PACE GRANT

In FY 2002, the National PACE Association awarded Rhode Island a grant to develop a Program of All-inclusive Care for the Elderly (PACE). PACE gives seniors access to a full range of preventive, primary, acute, and long-term care services, focusing on enabling enrollees to live in the community. The Rhode Island PACE steering committee includes representatives from various state agencies, consumers, the Legislature, the Governor's office, the Lieutenant Governor's office, and providers. Workgroups were established to identify issues and recommendations regarding rate setting, eligibility, enrollment, regulations and quality oversight.

In FY 2003, the University of Rhode Island College of Pharmacy and the Rhode Island Department of Human Services were commended by the National PACE Association for their successful partnership and the work achieved by the state PACE Coordinating Team and it's workgroups.

The following deliverables of the grant awarded in 2002 have been completed:

- Determined where PACE integrates into the state long-term care system;
- Drafted clinical and financial eligibility criteria;
- Established a licensing plan;
- Drafted a state plan amendment;
- Established a rate setting methodology;
- Established monitoring procedures;
- Developed human resource, administrative, and budgeting plans.

SYSTEMS CHANGE GRANTS FOR COMMUNITY LIVING

Real Choice Systems Change Grant

In fiscal year 2002, CMS provided the state with a Real Choice Systems Change grants aimed at building an infrastructure to support and sustain adult populations living in the community. (see Children with Special Health Care Needs for information on an additional grant.) Funded at $1.385 million over three years, the grant will: expand capacity to needed services; increase informed choices for consumers; and improve the integration of health and social services. The grant will be used to develop a web-based benefits screener and resource directory, develop service-tracking software, host a conference on community based services, conduct a needs-assessment survey of long-term care consumers, analyze Medicare data to identify patterns of individuals likely to become dually Medicare/Medicaid eligible, provide behavioral health consultation to non-institutional residences, track and analyze residential and community-based systems of care, and improve the transition for youth with serious emotional disturbances who transition to the community.

Nursing Facility Transitions Grant

The nursing facility transition grant was awarded in October 2002 by the Centers for Medicare and Medicaid Services. The program will: provide institutionalized persons with information on community service options; help interested persons transition to a community living arrangement with necessary supports; and enhance the capacity of the home and community based system to serve individuals with multiple or complex needs.

In FY 2003, there were 32 referrals to the program and 13 persons actually discharged from institutional settings. The program provided household furnishings for nine people, and case management services for all persons referred. The major barrier for many of those still waiting to transition is the difficulty finding affordable accessible housing. A Request-for-Proposals is being developed in order to start a day program for Rhode Islanders with significant cognitive disability. The start up funds for this day program will be paid for with grant funds.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

CHRONIC CARE PROGRAMS

Connect CARRE

Connect CARRE is a care management and wellness program that provides comprehensive services to consumers with declining health and frequent illnesses. The program involves ongoing analysis of service utilization patterns for health indicator screenings and chronic care and disease management.

Participants in Connect CARRE are at risk for recurrent adverse medical events that lead to frequent hospitalizations and emergency room visits. Participants live in community settings but often lack social and community supports.

Connect CARRE links consumers to a medical home and a team of providers and care coordinators, including a Lead Physician and a Nurse Care Manager. The program helps consumers develop more consistent and supportive relationships with their health care providers, assists consumers and their families to manage chronic illness through educational programs, and identifies and coordinates services and care in the community in order to help consumers maintain wellness and reduce recurrent illness.

The program utilizes a care management model and includes disease management principles that support physician practice. Connect CARRE's consumer focused model provides enhanced benefits and utilizes health outcomes as program measures. Based on an initial consumer needs assessment, the clinical team (nurse care manager, assistant medical director, pharmacist and social worker) develops a care plan. The Nurse Care Manager coordinates care management and services along the continuum. In addition to improving participant wellness, Connect CARRE strives to maintain or improve the individual's functional status, increases his or her ability to manage their care, and decreases preventable hospitalizations and emergency department use. The program helps DHS identify gaps in the current delivery system and increase capacity to meet the needs of the target population.

Connect CARRE enrolled over 100 members in FY 2003. Preliminary program analysis has shown a significant decrease in inpatient admissions and an increase in home care services and pharmacy. The program continues to provide clinical and social support to its members as well as supporting the practice of its participating physicians.

Connect CARRE expects to enroll up to 300 new members in FY 2004.

Dual Eligibles Diabetes Project

The DHS, along with DOH and DEA, participate as members of the task force formed by the Rhode Island Quality Partners (RIQP) in an effort to target dual eligible beneficiaries with diabetes who have Medicaid and Medicare, and are living in the community. The State, working with RIQP, has submitted a proposal to the Centers for Medicare and Medicaid Centers (CMS) and will be continuing work on this initiative in the coming fiscal year.

Department of Health Ocean State Immunization Coalition for Flu and Pneumonia Immunization in Community

The Ocean State Adult Immunization Coalition is a joint effort by DHS, DOH, Rhode Island Quality Partners, long-term care and home care agencies and the Visiting Nurses Association. The group is working to improve flu and pneumonia immunization rates for the over-65 and high-risk under 65 populations.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

Long Term Care/Nursing Facility Flu and Pneumonia Immunization Project

This project is a joint effort of DHS and the Department of Health. It provides education and technical assistance to help nursing facilities in their efforts to provide flu and pneumonia immunizations to all nursing facility residents and staff. The DOH monitors the project results to ensure that immunizations reach 100 percent.

DRUG UTILIZATION REVIEW

The Drug Utilization Review (DUR) Board oversees pharmaceutical use in Medicaid, in order to ensure that medications are utilized appropriately and cost-effectively. The Board is made up of physicians, pharmacists, and other health care professionals working in Rhode Island. The Board meets quarterly. In addition, DHS conducts prospective reviews through online edits and audits and in-pharmacy discussions with patients to ensure that duplicate or interacting medications are not prescribed. Health Information Designs, a contractor, conducts retrospective utilization review for Medicaid-payable prescription drugs, tracks trends in prescriptions, and provides information to help physicians improve their prescribing practices.

MEDICAL TRANSPORTATION

Many elderly citizens and people with disabilities receiving Medical Assistance need assistance with transportation to access medical services. Individuals are encouraged to seek help from friends, neighbors and families members. In addition, many health centers, community agencies and volunteer groups provide rides. When none of these are available, the state can provide assistance.

The Rhode Island Public Transportation Authority (RIPTA) provides "no fare" and free ride programs to Medical Assistance enrollees who apply for a RIPTA Senior/Disabled Bus Pass. The RIDE Program provides door-to-door transportation to medical appointments to people over age 60 and individuals with disabilities. Appointments require prior approval and must be made two weeks in advance of the date the transportation is needed.▼

CENTER FOR ADULT HEALTH

POPULATIONS & SERVICE EXPENDITURES

ADULTS WITH DISABILITIES

Population Characteristics

Medicaid's average monthly caseload of adults with disabilities (age 21 to 64) was 24,543 in fiscal year 2003. This is a six percent increase from the previous year. By disability, disease or illness, adult Medicaid enrollees with disabilities fell into one of three population groups:

- Individuals with developmental disabilities and mental retardation;
- Individuals who are severely and persistently mentally ill; and
- Individuals who are physically disabled and/or chronically ill.

These three groups have different health care needs, and, depending on each individual's need for care, services are provided in the community, in a nursing home or other residential facility.

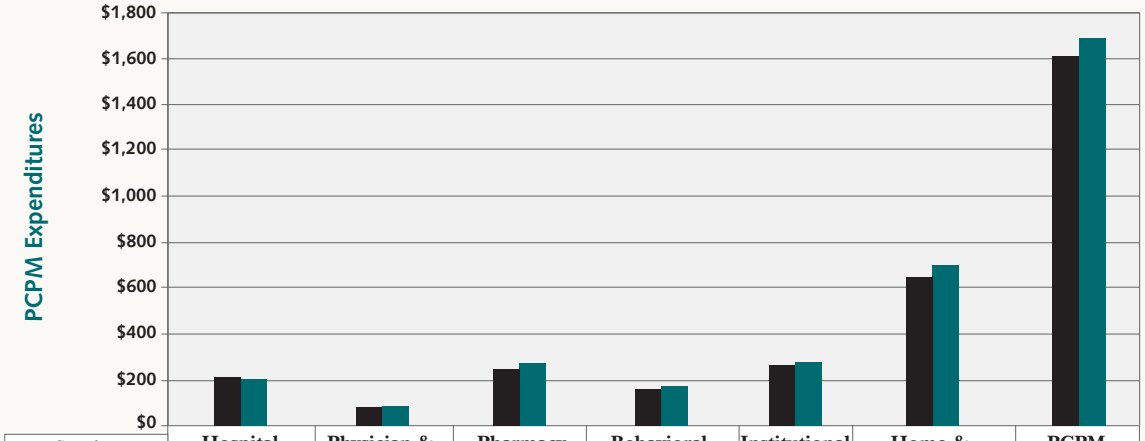
Services and Expenditures

In FY 2003, Medicaid spent $500 million on services for adults with disabilities, an 8 percent increase over the previous year. The average per client per month spending (PCPM) was $1,693. **Exhibit 14** shows the average monthly per-client Medicaid spending in these categories in fiscal years 2002 and 2003:

The average monthly expenditures per client grew five percent between fiscal year 2002 and 2003. Average monthly expenditures per client increased in every service provider category, except hospitals, which decreased, between 2002 and 2003. Home and community-based services remained by far the largest expenditure category, accounting for more than twice the spending of the next highest category, institution-based services. The three largest expenditure categories, accounting for over 70 percent of all expenditures, were as follows:

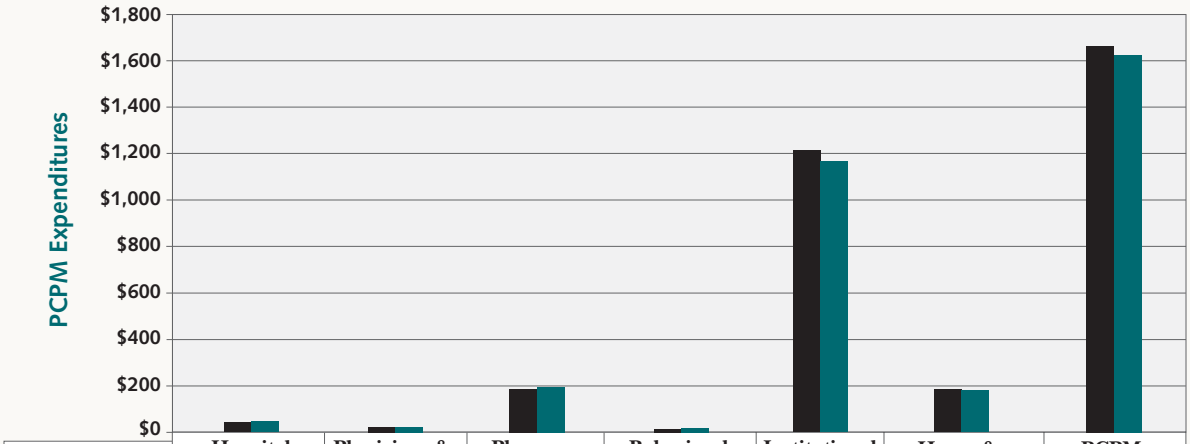
- $693 PCPM for home and community based services
- $272 PCPM for institutional services
- $263 PCPM for pharmacy

EXHIBIT 14
Adults with Disabilities
PCPM Program Expenditures by Service Provider
FY 2002 and FY 2003



Service Provider Category	Hospital	Physician & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM
FY 2002	$210	$82	$243	$167	$266	$644	$1,611
FY 2003	$203	$86	$263	$176	$272	$693	$1,693

EXHIBIT 15
Elderly Adults
PCPM Program Expenditures by Service Provider
FY 2002 and FY 2003



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM TOTAL
FY 2002	$45	$20	$187	$12	$1,208	$186	$1,659
FY 2003	$48	$20	$199	$14	$1,161	$183	$1,624

ELDERLY ADULTS

Population Characteristics

In fiscal year 2003, the average monthly caseload of recipients age 65 and over was 19,237, a four percent increase over FY 2002. Ninety (90) percent of Medicaid-funded nursing home residents were over 65 in fiscal year 2003.

Services and Expenditures

In fiscal year 2003, Medicaid spent over $391 million on services for aged recipients, an increase of two percent over FY 2002. Fiscal year 2003 PCPM expenditures for elderly recipients totaled $1,624, a decrease of two percent. Approximately 70 percent of expenditures, or $1,161 PCPM, for elderly recipients were for institutional services. Monthly per member costs for prescription drugs, the second largest category of monthly expenditures for the elderly population, rose six percent in fiscal year 2003. ▼

CENTER FOR ADULT HEALTH

TRACKING ACCESS, QUALITY & OUTCOMES

The Research and Evaluation Project continued to investigate the health needs of Medicaid-eligible adults with disabilities. Over the past several years, evaluations have been performed to collect information on this population, through focus groups, a statewide survey and analysis of baseline and comparison years' utilization data.

Using these research methods, the Research and Evaluation Project has identified several consistent themes. To begin with, many Medicaid enrollees have multiple health problems. Often individuals suffer from both mental and physical conditions. Adult Medicaid recipients who live with disabilities and chronic conditions have complex needs for a wide spectrum of services. Evidence shows that many individuals have unmet needs for disease, treatment and care information, would benefit from stable connections with providers, and need assistance with their full range of medical, psychological and social services. The CAH is using these findings to identify ongoing client needs, develop programs and improve existing efforts, in order to improve access to and quality of care for program participants. ▼

CENTER FOR CHILD & FAMILY HEALTH

PROGRAMS & INITIATIVES

The Center for Child and Family Health (CCFH) administers the delivery of health services for the following Medicaid/SCHIP populations:

- Children under age 19 living in families with incomes less than 250 percent of FPL
- Pregnant women with incomes less than 250 percent of FPL
- Parents of children with family incomes less than 185 percent FPL
- Children with special health care needs, including those eligible for Medical Assistance due to:
  - foster care (substitute placement) (up to age 21)
  - Subsidized adoptive placements (up to age 21)
  - Supplemental Security Income (SSI, up to age 21)
  - The Katie Beckett provision (up to age 18)

These populations receive health care services through either the RIte Care program or traditional fee-for-service Medicaid. Over the past two years, DHS has initiated strategies designed to stabilize growth in the RIte Care program, both by implementing RIte Share, Rhode Island's premium assistance program for employer-sponsored health care coverage, and through the implementation of cost-sharing for RIte Care and RIte Share families. In addition, since November 2000, the Department has worked to contain the growth in expenditures for services and enhance the quality, access and coordination of care for children with special health care needs by transitioning them into RIte Care. Beginning in 2001, the Department began operation of the CEDARR Initiative, a family-centered system of evaluation, care planning, family information and support and timely access to health services which augments the care of children with special health care needs.

RITE CARE FOR CHILDREN AND FAMILIES

RIte Care is Rhode Island's Medicaid managed care program for low-income and uninsured children, parents, and pregnant women. RIte Care was implemented in 1994 under a Section 1115(a) Waiver. The Waiver allowed Rhode Island to create a comprehensive, coordinated health care delivery system through competitively procured contracts with licensed Health Maintenance Organizations (Health Plans). RIte Care implementation changed the nature of the delivery system for Medicaid enrollees by enrolling members in a health plan, providing every member with his or her own primary physician and implementing standards for provider accessibility and responsiveness. A core goal was to increase access to appropriate, timely primary care, including preventive care and "sick visits", thus decreasing the reliance on less appropriate emergency department visits and reducing avoidable hospitalizations.

RIte Care has increased enrollee access to health care and improved health outcomes, while containing the growth of costs. Not all managed care is alike: RIte Care has several key design features specified in the Health Plan contracts that are quite different from health plans' commercial contracts. These design features, along with oversight and monitoring by the State, are key ingredients in RIte Care's success. Evaluations of RIte Care have shown very significant improvements in participants' access to timely primary care as well as specialty care. Choice has been expanded by providing access to a much wider network of primary care and specialist providers than had been available in fee-for-service Medicaid. Overall, 97 percent of enrollees indicate that they are very satisfied or satisfied with RIte Care - a percentage that has remained relatively consistent for the past five years.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

RIte Care has had a significant impact on the uninsured in Rhode Island. At its inception, 11.5 percent of the total population and 9 percent of children were uninsured. In 2000, the uninsured population in Rhode Island had dropped to 6.2 percent and 2.4 percent, respectively, the lowest in the nation. Unfortunately, as a result of erosion in employer-sponsored coverage, Rhode Island's uninsured population increased to 7.7 percent of the total population and 4.5 percent of children, in 2001, and increased again in 2002 to 9.8 percent of the total population and 4.7 percent of children. Despite this concerning increase Rhode Island has one of the lowest percentages of uninsured in the nation.

As of June 30, 2003, 119,257 were enrolled in RIte Care. This total includes 2,039 children in foster care (also referred to as children in substitute placement) who were enrolled in NHPRI. Health Plan enrollment as of that date was distributed as follows:

- NHPRI: 67,558
- United: 41,062
- Blue Chip: 10,637

RIte Share for Children and Families

The RIte Care Stabilization Act of 2000 established the RIte Share program, a combined Medicaid/SCHIP premium assistance program intended to support families in their efforts to obtain or maintain private, employer-sponsored health insurance. RIte Share pays (all or part of) an eligible families employer-based health insurance cost, as long as that cost is less than a family's cost of coverage under RIte Care, in other words, if it is more "cost-effective" for the State to pay the employee's share of the employer-sponsored premium than to pay the RIte Care premium. Enrollment in RIte Share is mandatory for Medicaid-eligible individuals whose employer offers an approved health plan. Enrollment of both employees and employers in the RIte Share program has continued to grow. As of January 2002, 117 employers were approved for participation in RIte Share. As of July 2003, 788 employers were approved for participation in RIte Share.

Since the program started, DHS has been transitioning RIte Care members into RIte Share. At the time RIte Share became mandatory, DHS estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RIte Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

In order to transition a RIte Care member to RIte Share, employers must provide DHS with information about their health insurance plan and employee contributions. Changes in the commercial health insurance market present additional challenges to RIte Share. For example, more and more employers are adopting health plans with front-end deductibles and greater differentials in coverage levels for in-network benefits. An employer can mitigate large rate increases through the magnitude of deductibles. For example, a $200 deductible could reduce the premium rate by, say, 3 to 4 percent, whereas, a $750 deductible could reduce the premium rate by, say, 9 or 10 percent. While plan design changes can mitigate the cost of commercial coverage to a certain extent, the cost of coverage may still prove to be too much for employers (and employees) particularly in a “down economy”.

As of June 2003, 4,268 individuals were enrolled in RIte Share. At the current level of effort and given the limitations of needed information received from members and employees about available coverage, DHS can transition between 150 to 200 RIte Care members to RIte Share each month.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

In FY 2003 RIte Share payments to employer-sponsored health plans totaled $2.6 million, or $72 per member per month (pmpm). This represented a savings of $76 pmpm over the RIte Care average cost of $150 pmpm. In total, RIte Share saved an estimated $2.8 million ($1.0 million State) in SFY2003 and is expected to save $3.4 million ($1.2 million State) in SFY2004.

COST-SHARING FOR CHILDREN AND FAMILIES

The RIte Care Stabilization Act of 2000 also mandated cost-sharing for RIte Care and RIte Share families with family income above 150 percent of the FPL ($22,890 for a family of three). As of August 1, 2002, state law mandated that cost-sharing be raised to approximately five percent of FPL. This amount ranges from about $61 to $92 per month.

Monthly premiums are collected in two ways:

- For RIte Care, DHS sends a bill and the family pays DHS directly by mailing a check.
- For RIte Share, DHS deducts the monthly premium from the amount it reimburses the member for the employee's share of employer coverage.

The average number of families subject to cost sharing is 4,300 which is about 10 percent of all RIte Care and RIte Share enrollees. Any family who is two months in arrears is disenrolled from coverage and can not re-enroll for four months. An average of 150 families a month are sanctioned for failure to pay premiums.

In total, $3.28 million ($1.2 million in State general revenue) were collected from family cost sharing in FY 2003.

IMPACT OF RITE SHARE AND COST-SHARING ON RITE CARE

In FY 2003, combined RIte Care and RIte Share enrollment growth averaged 404 individuals per month. This reflects a continued reduction in the rate of growth when compared to previous years:

- In FY 2000, RIte Care enrollment growth averaged 1,452 per month. This was during the time of crisis in Rhode Island's health insurance market, discussed earlier in this report.
- In FY 2001 and FY 2002, RIte Care and RIte Share enrollment growth averaged 501 and 547 per month, respectively (excluding foster children transitioned from FFS Medicaid to RIte Care).

The implementation of RIte Share and cost-sharing has achieved its intended purpose of stabilizing growth and expenditures of RIte Care.

TRANSITIONING CHILDREN WITH SPECIAL HEALTH CARE NEEDS INTO RITE CARE

Beginning with Children in Foster Care

In FY 2001, RIte Care began enrolling children in foster care (also referred to as children in substitute placement). Children in foster care are categorically eligible for Medicaid, but had remained in fee-for-service because of concerns about how managed care would address their needs. Historically, 70 percent of foster care children had previously been RIte Care members. In preparation for the RIte Care enrollment of children in foster care, the Department of Children, Youth and Families and DHS established governing principles for the partnership and invited Health Plans to participate. Currently, only NHPRI enrolls children in foster care.

The partnership between DHS, DCYF and NHPRI facilitated several system changes. The behavioral health provider network available to children in foster care was substantially strengthened by including all DCYF active and specialty behavioral health providers in the NHPRI behavioral health provider network. The DCYF and NHPRI have developed a data exchange capability that enables daily data exchanges between organizations. This exchange provides NHPRI with current placement information on these children and gives DCYF the name of each child's current primary care provider.

As of July 2003, 2,039 children in foster care were enrolled in RIte Care.

Children in SSI, Katie Beckett and subsidized adoptive placements

In FY 2003, approximately 8,500 children with special health care needs (including children in, SSI, Katie Beckett and subsidized adoptive placements but excluding children in foster care (substitute placement)) received health care through Rhode Island Medicaid on a fee-for-service basis. Almost two-thirds of these children qualified for Medicaid due to Supplemental Security Income (SSI) eligibility, which is based on the family's income and the child's health status. An additional twelve percent of the these Medicaid-eligible children with special health care needs qualified under the "Katie Beckett" provision, where eligibility is based upon the child's (not the parents') income and resources and the determination that the child needs an institutional level of care and the cost of caring for the child at home is less than the cost of care in an institution. The remainder of the non-RIte Care enrolled children with special health care needs were Medicaid-eligible by virtue of their qualification under Rhode Island's adoption subsidy program.

A Governor's budget initiative for FY 2003 directed DHS to design a service delivery strategy that would allow Medicaid eligible children with special health care needs (with the exception of children in foster care who had already been transitioned into RIte Care in FY 2001) to be enrolled in RIte Care and have their routine and specialized health care needs met through the participating health plans. The DHS began implementing this initiative in FY 2002, pursuing input from a broad range of stakeholders and seeking approval of the project from the federal Centers for Medicare and Medicaid Services (CMS). To gain approval, DHS amended its existing RIte Care Section 1115 Research and Demonstration Waiver. Federal approval was received on January 29, 2003.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

Based on the successful enrollment of foster children, the State believes children with special health care needs can benefit from improved access to care and service coordination afforded through RIte Care, by utilizing a service delivery strategy focused on the children's unique needs, the strengths of the family, and coordination of services. Enrollment in RIte Care will expand provider availability and access to quality, timely provision of services. Slowing the rate of increases in costs is an anticipated by-product of improved care.

Families of children with special health care needs can voluntarily enroll their Medicaid eligible child in RIte Care through Neighborhood Health Plan of Rhode Island (NHPRI). DHS requires that NHPRI maintain a specialized care management program for these children. Enrollment commenced on September 2003.

CEDARR

The Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) Initiative is a family-centered, strength-based and comprehensive system of family information and support , diagnostic evaluation, care planning, and linkage to health services for children with special health care needs who are Medicaid-eligible. The CEDARR Initiative was developed based on the recommendations of the Leadership Roundtable on Children with Special Health Care Needs, a representative group of family members, providers, public and private administrators and advocates convened for planning purposes by the Director, Department of Human Services.

The CEDARR Initiative is comprised of two major efforts: (1) CEDARR Family Centers, which began operating in FY 2001; and (2) CEDARR Direct Services. CEDARR Direct Services are specific services developed pursuant to the CEDARR Initiative and available to Medicaid beneficiaries when included as a part of an approved CEDARR Family Center Care Plan. Development of CEDARR Direct Services is based on two principles:

- Identification of current service needs and gaps in health care services for children with special health care needs and their families; and
- Establishment and operation of an accountable system for the purchase of appropriate, high quality services to meet those needs.

In addition to RIte Care enrollment, families of children with special health care needs may also access CEDARR Family Centers to assist with identification of needs and strengths, develop an appropriate plan of care and navigate the health care delivery system. CEDARR Family Centers collaborate with all RIte Care health plans to coordinate services and supports that are delivered through the health plans and through fee-for-service Medicaid.

CEDARR Family Centers

The CEDARR Family Centers provide:

1. Basic services and supports:
   - Provision of special needs resource information
   - Health needs coordination counseling
   - System mapping and navigation
   - Peer family guidance
   - Therapeutic intervention consultation
   - Initial family assessment
2. Specialized services:
   - Clinical capacity in specialty areas
   - Crisis intervention and triage
   - Comprehensive evaluation and diagnostic assessment
   - Family care plan development, review and revision
   - Family care coordination assistance
   - Quality assurance/data collection/outcome measures

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

The CEDARR Family Center assigns a Family Service Coordinator and clinician to each child and his or her family. The CEDARR Family Service Coordinator is often a parent or a caregiver of a special needs child. The CEDARR Family Center staff provide information, identify needed services, make referrals and assure the coordination of care among the child's physician, the child's school and other service providers. Services are available statewide and there are no out-of-pocket expenses for Medicaid eligible children.

In FY 2003, the CEDARR Family Centers assisted 756 children and their families. Of the children accessing a CEDARR Family Center in FY 2003, two-thirds were male, ten percent spoke a primary language other than English, and over half were under age 8 at first contact. CEDARR Family Centers served children and families from all 39 cities and towns in Rhode Island.

In FY 2003 four CEDARR Family Centers were in operation around the state. "About Families" opened in FY 01, and "Family Solutions" and "Families First" opened in July 2001 and July 2002, respectively. A fourth center, "Easter Seals CEDARR," opened in October 2002.

The CEDARR Quality Panel, which is composed of members of the interdepartmental CEDARR team and clinical staff from CEDARR Family Centers, convened in November 2001. The group meets monthly to identify the issues, strengths and challenges of CEDARR Family Centers, and to identify best practices that will assure family satisfaction and positive outcomes for children.

In FY 2003, a CEDARR Family Survey was conducted to assess the experiences of families who made use of a CEDARR Family Center. Families indicated a high level of satisfaction with the family centered practices employed by the CEDARR centers. The results of the survey will be used as a baseline for future measurement of the effectiveness of the CEDARR Family Centers.

CEDARR Direct Services

When fully implemented, CEDARR Direct Services will improve access to the continuum of care for children with special health care needs. In FY 2003, certification standards were issued for Therapeutic Services in Child and Youth Care (TCYC). TCYC is provided for Medicaid eligible children living at home and who have been diagnosed with certain significant physical, developmental, behavioral or emotional conditions. These services are intended to support the participation of these children in typical child and youth care settings where such participation is determined to have potential positive benefits for the child.

Therapeutic Child and Youth Care is a specialized service delivered in DCYF licensed child or youth care centers. It is a program of care designed to maximize the inclusion and participation of Medicaid eligible children and youth with special health care needs who have been dismissed from or previously unable to participate in child and youth care settings.

In order for inclusion in child and youth care to truly be accomplished, children and youth with special health care needs must interact with their peers, who are typically developing, in a socially meaningful manner. This means that physical and social isolation in child and youth care must be avoided. Children or youth in TCYC must have the opportunity and supports necessary for them to engage and interact with children who are typically developing while they mutually participate in the activities in the child and youth care setting. This may, at times, require that children who are typically developing also be given help in interacting with their peers who have special health care needs. TCYC does not include the basic child or youth care itself that is billed separately to the family or other payer.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

SCHOOL-BASED HEALTH SERVICES

Approximately 50 percent of the children who receive special education services in Rhode Island are Medicaid eligible. All Rhode Island school districts are participating Medicaid providers. The DHS works with Local Education Agencies (LEAs) and the Department of Education to maximize local schools' ability to receive Medicaid funding for needed medical and dental care provided to Medicaid eligible students. In FY 2001, an administrative claiming program was implemented. This resulted in $22.2 million in LEA revenue in FY 2002 and $26.2 million in FY2003.

LEAD CENTERS

In 2003, DHS expanded its Lead Center program, certifying an additional three Lead Centers. The Department monitors and oversees the Centers' compliance with certification standards developed in 1998 and revised and reissued in 2002. Certified Lead Centers assist families through intensive case management, coordination of housing inspections, relocation assistance, family education, training on cleaning techniques, referrals to medical, legal, nutritional, early intervention, special education, intensive environmental cleaning and other services. The Department reimburses for window replacement costs in the homes of RIte Care enrolled children with significant lead poisoning.

The four Certified Lead Centers are:

- Blackstone Valley Community Action Program
  32 Goff Avenue
  Pawtucket, RI 02860
- Family Services of RI
  5 Hope Street
  Providence, RI 02906
- HELP Lead Safe Center
  21 Peace Street
  5th Floor
  Providence, RI 02907
- West Bay Community Action Program
  205 Buttonwoods Ave.
  Warwick, RI 02886

In FY 2003 the Lead Centers provided services to 282 children.

DRUG COURT

The Rhode Island Family Court, Attorney General, Public Defender, DCYF, MHRH, DOH and DHS collaborated to plan and develop the Rhode Island Family and Juvenile Drug Court. The Juvenile Drug Court grew out of a recognized need for a therapeutic approach to nonviolent juveniles whose involvement in Family Court is attributable to their dependency upon alcohol and other drugs. In addition, there is evidence that a specialized court can enhance public safety by breaking the cycle of recidivism.

Juvenile Drug Court was launched in December 1999. In FY 2003, one hundred one (101) participants were admitted to the program. Forty-one (41) graduated during the year. Through a series of amended administrative orders, the program was expanded from Providence and Bristol Counties to cover juveniles living anywhere in Rhode Island.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

RWJF STATE COVERAGE INITIATIVE PROJECT

In FY 2002, Rhode Island was one of only four states to receive a three-year demonstration grant from the Robert Wood Johnson Foundation's State Coverage Initiative (SCI) Program. The SCI demonstration grants are targeted to states that are ready to achieve a sizable coverage objective, such as significantly reducing the number of working uninsured or designing a novel coverage model or partnership. Rhode Island's project is designed to reduce the level of uninsured in the state by fully implementing RIte Share. Major grant activities include: (1) conducting a formative evaluation of RIte Share operations to ensure that the program is designed to maximize enrollment and budgeted cost-savings, and using this evaluation to create a how-to manual for other states starting premium assistance programs; (2) developing and implementing a management information system for RIte Share that facilitates monitoring and continuous improvement in the areas of enrollment, cost-effectiveness and access to appropriate, effective health care services; (3) conducting, in partnership with the Department of Health, a statewide survey of patterns in employer health insurance to assess trends from a similar survey conducted in 1999 and to elicit feedback from employers concerning RIte Share; (4) conducting a study of the impact of "churning" (frequent change of coverage status) on access to care for Rhode Island's low-income working population; and (5) in partnership with the Brown Medical School, establishing a research fellowship that will facilitate the application of Brown's significant health services research capacity into Rhode Island Medicaid's design and evaluation.

PERSONAL ASSISTANCE SERVICES AND SUPPORTS (PASS) GRANT

In FY 2002, CMS awarded DHS and its partners a Community-Integrated Personal Assistance Services and Supports (PASS) grant. This grant supports the design and implementation of a consumer directed program for children with special health care needs living in the community. The Center for Child and Family Health is developing definitions and standards for this new service in order to expand the continuum of care for children with special health care needs. There is ongoing participation with consumers, advocates and potential provider organizations in the development of this Medicaid service Once implemented, the program will maximize control and choice for these children and their families as they seek to meet their children's personal needs. Implementation of this service is anticipated to be in FY 2004.

RHODE ISLAND ORAL HEALTH ACCESS PROJECT

In December 2002, the Robert Wood Johnson Foundation's Center for Health Care Strategies awarded Rhode Island $940,000 for a three-year period for the *Rhode Island Oral Health Access Project*. Rhode Island was one of six states to receive this award. Rhode Island Department of Human Services (DHS) anticipates receiving $940,000 in federal Medicaid matching funds for a total of $1.88 million over a three-year period.

The components of the project will include: (1) the Medicaid dental benefit for children and families will be restructured to improve access to dental care with emphasis on preventive and primary dental care while containing the growth in costs to the current trend rate. This will allow DHS to develop a more commercial-like benefit and contract with a dental plan manager through a competitive bid process. (2) community-based efforts will be supported to increase access to dental care in underserved areas and to increase the supply of dental professionals. Though a partnership with The Rhode Island Foundation and Rhode Island KIDS COUNT, performance-based grants will be awarded to increase access to dental services and increase workforce capacity. Grants will be awarded through a competitive bidding process.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

HRSA STATE PLANNING GRANT PROJECT

In October 2003, Rhode Island was awarded $961,156 in federal funds from the United States Department of Health and Human Services, Health Services and Resources Administration (HRSA) to develop a *Plan for Providing Access to Affordable Health Care Coverage for All Rhode Islanders.* Under this 12- month project, the Governor will convene a Steering Committee whose members will represent private and public purchasers of health care and state government.

DHS will be the State's lead agency for administering the project. The Project Management Team will build on the management structure of the Center for Family and Child Health and the project structure of Rhode Island's State Coverage Initiative (SCI) Project outlined above. The Project Director and Project Management Team Leader will be the Administrator of the Center for Child and Family Health. Key staff from the Departments of Administration, Health and Business Regulation plus the Economic Development Corporation will provide advice in their areas of expertise and will collaborate as members of the team.

The Steering Committee will consider national and Rhode Island-based research and policy analysis concerning the uninsured, the health care system, public and private health care coverage, and the health care marketplace and its regulation.

Experts will be brought in to assist the Steering Committee in understanding the options fully and their potential for Rhode Island. Each option will be assessed as to its applicability and viability, with the ones holding the greatest promise being simulated to determine their potential cost. The need for State legislation, Medicaid State Plan amendments, and/or Federal Waivers will be explored as necessary mechanisms to implement options. The Steering Committee will submit a report to the Governor summarizing its work and the Governor will submit the required report to the Secretary of the U.S. Department of Health and Human Services by the end of the grant period. ▼

CHILD & FAMILY HEALTH

POPULATION & SERVICE EXPENDITURES

CHILDREN & FAMILIES IN MANAGED CARE

Population Characteristics

Rite Care-Children and Families

In FY 2003, children under age 18 accounted for 65 percent of the 117,877 people in the RIte Care average monthly caseload. Approximately three-quarters of the adults were female. Ninety-six (96) percent of RIte Care members had household incomes below 185 percent of the federal poverty level (FPL), or below $28,230 for a family of three. Twenty-two (22) percent of the population spoke a language other than English as their primary language spoken at home. The second most common language, Spanish, was spoken by 18 percent of RIte Care members.

CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

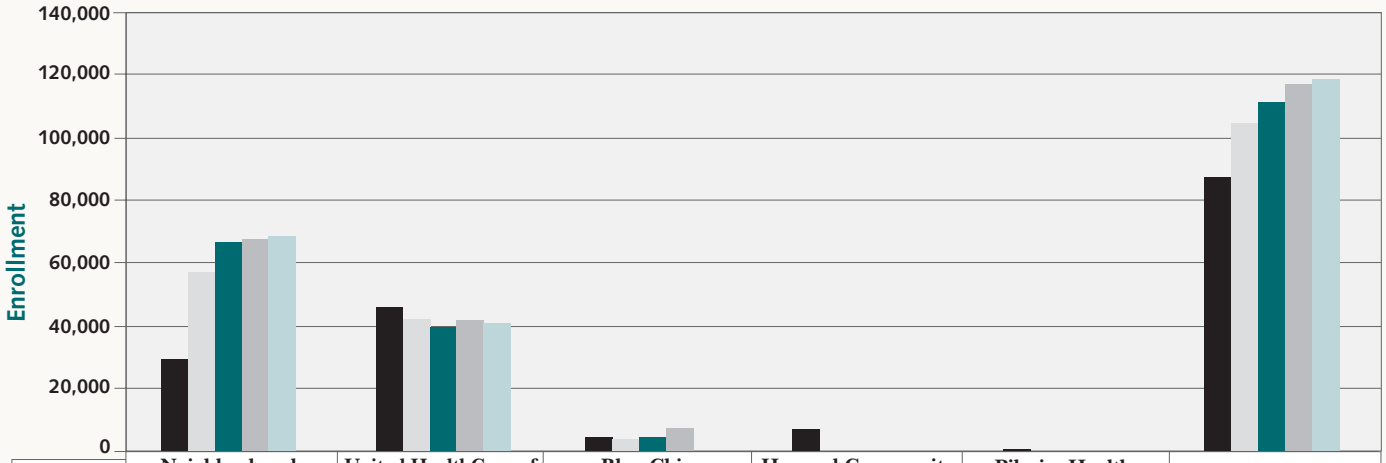
In 1997, RIte Care enrollment was distributed across three to five health plans (see **Exhibit 16**). When Harvard Community Health Plan and Pilgrim Health Plan left Rhode Island early in FY 2000, enrollees were transferred into the only RIte Care health plan still open to new enrollees, Neighborhood Health Plan of Rhode Island (NHPRI). Both United Healthcare of New England and Blue CHiP began accepting new Medicaid enrollees in FY 2001. At the end of the FY 2003, 57 percent of all RIte Care members were enrolled through NHPRI. United Healthcare and Blue CHiP had 34 percent and 9 percent of RIte Care members, respectively.

RIte Share - Children and Families

In FY 2003, RIte Share's average monthly caseload was 3,018. Sixty-four (64) percent of the caseload were children under age 18. Based on December 2003 data, Of RIte Share's total enrollees:

- 33 percent were enrolled in Blue Cross/Blue Shield of RI's Healthmate product
- 32 percent were enrolled in United Health Care of New England
- 18 percent were enrolled in BlueChip
- 17 percent were enrolled in fifteen (15) other health care products

EXHIBIT 16
RIte Care Enrollment* by Health Plan
FY 1999 to 2003



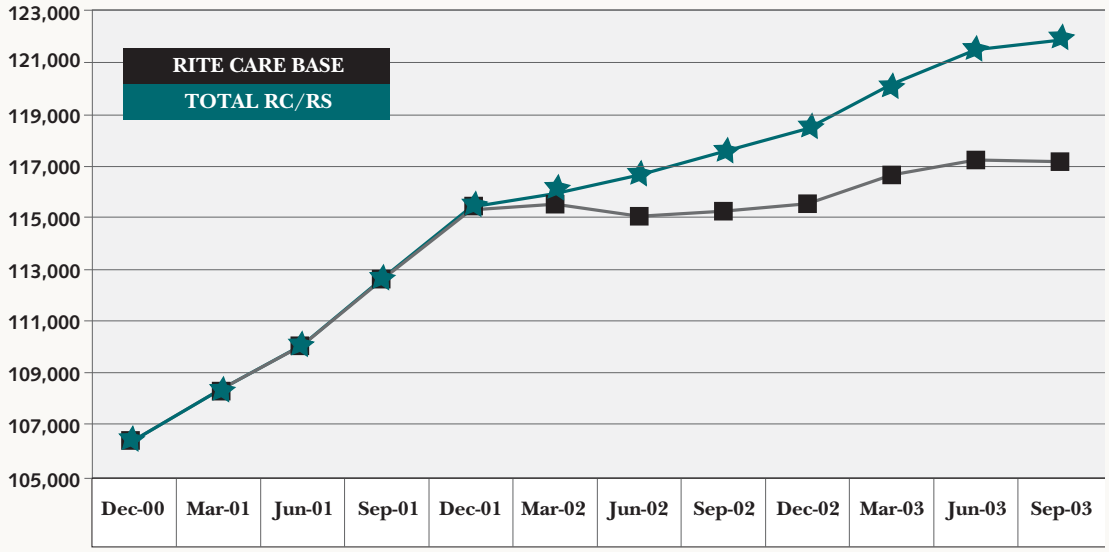
Health Plan	Neighborhood Health Plan	United HealthCare of New England	Blue Chip	Harvard Community Health Plan	Pilgrim Health Plan	TOTAL
1999	29,130	46,250	4,965	7,344	28	87,717
2000	57,315	42,747	4,381	--	--	104,443
2001	67,057	39,964	4,603	--	--	111,624
2002	67,410	41,900	7,714	--	--	117,024
2003	67,558	41,062	10,637	--	--	119,257

*Unduplicated count by health plan

CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

Exhibit 17 displays combined enrollment trends in RIte Care and RIte Share. Beginning in January 2002, RIte Care enrollment leveled-off as new applicants and existing RIte Care members with access to employer-sponsored health insurance were enrolled in their employer's coverage through RIte Share.

EXHIBIT 17
RIte Care/RIte Share Enrollment Trends
December 2000 to September 2003



Services and Expenditures

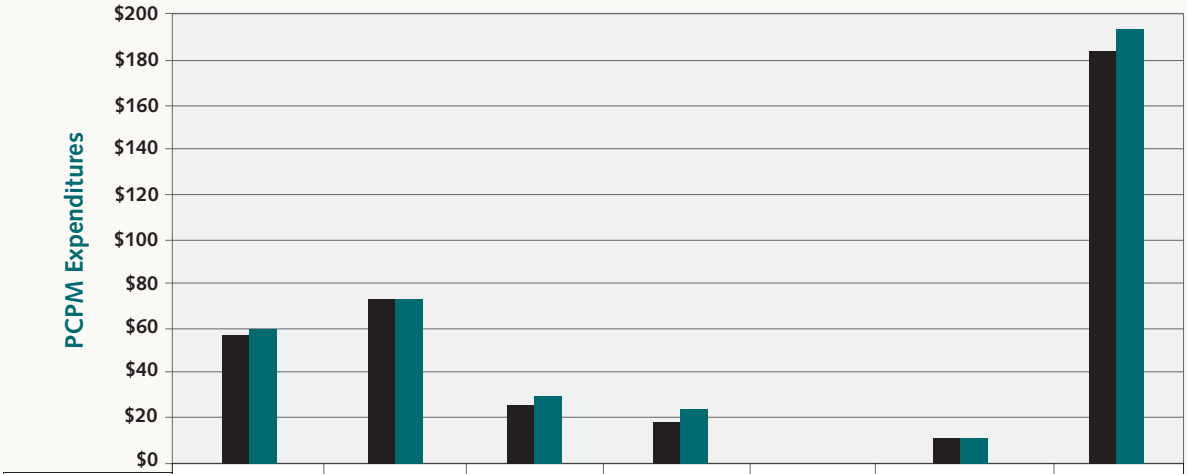
Rite Care - Children and Families

In FY 2003, total Medicaid expenditures for RIte Care children and families were $279 million an increase of six percent over the previous year. **Exhibit 18** displays FY 2003 average per client per month (PCPM) expenditures by service for children and families in managed care. The total PCPM includes services funded by DHS, DCYF and the LEAs for capitation payments to health plans, additional funds paid to health plans for services provided beyond the capitation package (such as unlimited mental health services), and funds paid directly to providers for services not provided by the health plans (including dental and transportation). Between FY 2002 and FY 2003, the total PCPM grew five percent to $194. The three largest expenditure categories, accounting for over 80 percent of all expenditures, were as follows:

- $72 PCPM for physician and other professional services (including outpatient hospital services)
- $60 PCPM for hospital services (including inpatient and emergency department services)
- $29 PCPM for pharmacy

EXHIBIT 18

Children & Families in Managed Care*
PCPM Program Expenditures by Service Provider
FY 2002 and FY 2003



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services*	PCPM
FY 2002	$57	$72	$25	$18	--	$11	$184
FY 2003	$60	$72	$29	$23	--	$11	$194

*excludes RIte Share

RIte Share-Children and Families

In FY 2003, total Medicaid expenditures for RIte Share children and families were $4.4 million, reflecting $2.6 million in premium payments to employer-sponsored health plans to pay the employee share of premiums and $1.8 million for Medicaid services not covered by employer-sponsored coverage. The total per client per month (PCPM) cost of RIte Share coverage was $121 distributed as follows:

- $72 PCPM for the employee's share of employer-sponsored health plan premiums
- $49 PCPM for services not covered by the employer-sponsored health plan

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Population Characteristics

An average of 12,149 children with special health care needs were served in Medicaid each month during FY 2003, an increase of eight percent from the previous year. Children in this subgroup are eligible for Medicaid because they are enrolled in SSI, under the Katie Beckett provision, in adoption subsidy or in foster care (substitute placement).

Eligibility for SSI is based on family income and the child's health. Children with special health needs receiving an institutional level of care in the home who do not meet SSI financial eligibility requirements may be found Medicaid eligible if they meet the requirements of the Katie Beckett provision. "Katie Beckett" eligibility is based on: (1) the child's income and resources only (not the parents'); and (2) a calculation that the cost of caring for the child at home is less than the cost of care in an institution.

CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

A third group of children with special health care needs is made up of individuals under age 21 who have been adopted through subsidized adoptive arrangements. The agreement between the state and the adoptive parents includes a provision indicating that the child will remain Medicaid eligible until he or she turns 21.

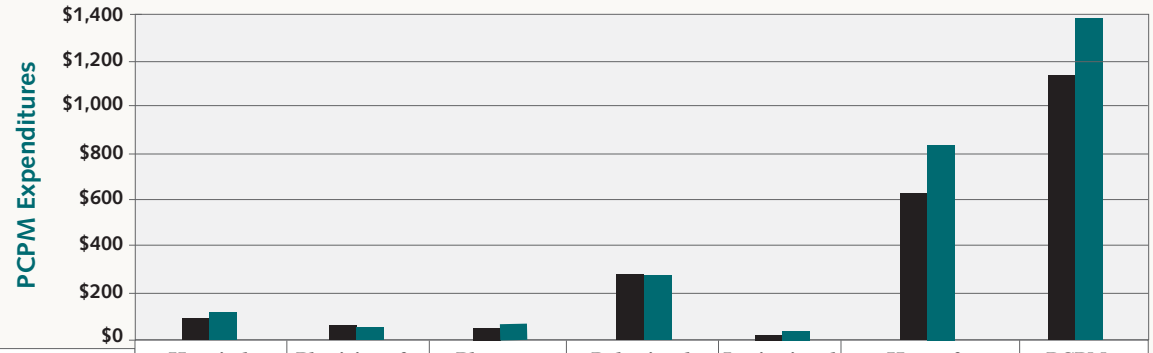
Children in foster care (substitute placement) are placed in foster care under the child protective services of the Department of Children, Youth and Families due to neglect and physical, sexual or emotional abuse. Children in foster care, up to age 21, are eligible for Medicaid.

Services & Expenditures

Total Medicaid program expenditures for this population were $189 million, an increase of 23 percent from FY 2002 expenditures. The total per capita per month (PCPM) spending was $1,395. As displayed in **Exhibit 19**, two service provider categories represented over 80 percent of all expenditures, i.e.:

- $834 PCPM for home and community-based services (including EPSDT services, intensive home-based therapy, private duty nursing, and certified nursing assistant services)
- $282 PCPM for behavioral health services.

EXHIBIT 19
Children with Special Health Care Needs
PCPM Program Expenditures by Service Provider
FY 2002 and 2003



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM
FY 2002	$91	$60	$50	$289	$23	$626	$1,139
FY 2003	$117	$57	$63	$282	$42	$834	$1,395

CHILD & FAMILY HEALTH

TRACKING ACCESS, QUALITY AND OUTCOMES

CHILDREN AND FAMILIES IN MANAGED CARE

In order to measure RIte Care's impact on health care access, quality and outcomes, Rhode Island Medicaid established the Research and Evaluation Project within the Division for Health Care Quality, Financing and Purchasing. The Research and Evaluation Project evaluates what programs work and how change occurs.

Throughout most of the 1990s, research and evaluation efforts focused on the children and families enrolled in RIte Care. As the RIte Care evaluation began to show that the program had a positive impact on health status and outcomes for the target population, Medicaid began expanding the Research and Evaluation Project to other population groups.

For the past eight years, Medicaid has been measuring RIte Care's access, quality and outcome effects. This has allowed the program to track progress in the health and health care of the population over time. RIte Care enrollees have experienced significant improvements in their access to health care and health status, including primary, pediatric, and prenatal care, increased inter-birth intervals, decreased maternal smoking, positive trends in low-birth weight among RIte Care newborns, and increased childhood immunization and lead screening rates as follows:

- Decrease in the uninsured population. Rhode Island's coverage expansions have decreased the uninsurance rate of children. The percentage of uninsured children in Rhode Island dropped from 12.5 percent in 1995 to 2.4 percent in 2000, the lowest in the nation. Unfortunately, as a result of erosion in employer - sponsored coverage, uninsured children in Rhode Island increased to 4.5 percent in 2001, and 4.7 percent in 2002. Despite this increase, Rhode Island has one of the lowest percentages of uninsured children in the nation.
- Increased inter-birth interval. RIte Care has positively impacted maternal health. An increasing number of women on Medicaid wait at least 18 months between births, from 60 percent before RIte Care implementation (1993-94) to 70 percent in 2001. Women receiving Medicaid and those with commercial health insurance now have inter-birth intervals of similar length.
- Reduction in smoking during pregnancy. The percentage of pregnant women on Medicaid who smoked during pregnancy decreased significantly, from 32 percent in 1993 to 23 percent in 2001.
- Improved access to prenatal care. In 2001, 85 percent of women on Medicaid began prenatal care in the first trimester, up from 77 percent in 1993.
- Increased adequacy of prenatal care. The number of women on Medicaid receiving adequate prenatal care increased significantly, from 56 percent in 1993 to 74 percent in 2001.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Recent studies on children with special health care needs indicated room for improvement in the care of these children. Central are the opportunities to enhance quality, access and coordination of care for children with special health care needs. The State plans to build on RIte Care's successes by enrolling children with special health care needs into the program's participating health plans in FY 2004.

CHILD & FAMILY HEALTH - TRACKING ACCESS, QUALITY AND OUTCOMES

In calendar year 2000[5], 12,062 children were enrolled in the four subgroups that encompass children with special health care needs: children eligible due to SSI (45%); children in subsidized adoptions (38%); children eligible due to the Katie Beckett provision (8%) and children in foster care (substitute placement) (8%). The DHS reviewed utilization data for these children, finding:

- The annual hospitalization rate per 1,000 individuals was 173. Children in foster care (substitute placement) had the highest rate of hospitalization, at 262 per 1,000 children.
- Over 7 percent of all children with special health care needs were hospitalized. Of those hospitalized, over 21% had a length of stay greater that 30 days. Thirty-two percent of children in foster care were hospitalized for longer than 30 days.
- Mental disorders were the leading cause of hospitalization for all four groups. Eighty-seven percent of hospitalizations for children in foster care were for mental disorders.
- Fifty-seven percent of the children with hospitalizations were admitted more than once.
- The emergency department visit rate for children with special health care needs was 443 per 1,000. Children enrolled due to SSI eligibility have the highest rate of emergency department visits, at 599 per 1,000.

5 calendar year 2000 is the most recent year for which utilization information is available

WEB SITE LINKS

Look on the DHS web site: www.dhs.ri.gov for the following links to find more information about topics discussed in this report.

- What is Medicaid?
  - History of Medicaid
- How is RI Medicaid Administered?
  - Partnerships for Serving the RI Medicaid Population
- Who is Eligible?
- What Services are covered?
- How is Medicaid Financed?
- How is Rhode Island's Medicaid Budget Determined
  - Caseload Projections & Budget Forecasts
- What is a Waiver?
- Research & Evaluation Project
  - 2001 description
  - Evaluation Studies Work Group
  - Publications

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